COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

November 1, 2015

The Honorable Kent Lambert, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Senator Lambert:

Enclosed please find the Department of Health Care Policy and Financing's response to the Joint Budget Committee's Request for Information #1 comparing Medicaid reimbursement rates for services to Medicare.

Legislative Request for Information #1 states:

*The Department is requested to submit a report to the Joint Budget Committee, by November 1, 2015, comparing Medicaid reimbursement rates for services to Medicare. For codes without a comparable Medicare rate, the Department shall find and identify a data source that will estimate the usual and customary rate paid in a commercial health plan. The Department shall include the reasoning behind the selection of data sources used to estimate the usual and customary rate. The report shall be submitted in a format that provides the ability to estimate the cost of bringing Medicaid rates to a variable percentage of the applicable Medicare rate or usual and customary rate. For codes unique to the Medicaid program, the Department is requested to collect comparable data from other states' Medicaid programs when and if available. For any codes for which the Department cannot find a comparison rate, the Department shall list the codes, the current Medicaid rate, and the reason the Department was unable to find a comparison. Capitated rates, cost-based rates, and rates that are based on a methodology defined in statute shall not be included in the report, except that the Department will estimate the portion of total expenditures paid through each of these methods.*

The following report contains a comparison analysis of reimbursement rates effective January 1, 2015 used by the Colorado Medicaid program with reimbursement rates used by Medicare, other states or the usual and customary rate paid in a commercial health plans as specified in the request.

The report includes specifications of services included for analysis. The eight areas of services included in the report are: Practitioner, Home and Community Based Services Waiver, Home Health/Private Duty Nursing, Dental, Early and Periodic Screening, Diagnostic and Treatment, Independent Laboratory, Transportation and, Durable Medical Equipment/Supplies. Accordingly,

information regarding the data used, evaluation methodologies, rate comparisons summaries and fiscal impact on payment for these services projected to FY 2016-17 are included.

The report also references those services *excluded* from the analysis following the guidelines of the LRFI request. Those are: capitated rates, cost-based rates, and rates that are based on a methodology defined in statute. Supplementary information is also included for additional rates or service *removals* based on further evaluation of the data where an equivalent comparison rate was not possible to determine.

Finally, the report includes a section with overall conclusions and recommendations for future benchmark work as well as an Appendices section with detailed information relevant to this report.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Zach Lynkiewicz, at Zach.Lynkiewicz@state.co.us or 720-854-9882.

Sincerely,

Susan E. Birch, MBA, BSN, RN
Executive Director

SEB/kam
Enclosure(s): Health Care Policy and Financing FY 2015-16 RFI #1

Cc: Representative Millie Hamner, Vice-chair, Joint Budget Committee
Representative Bob Rankin, Joint Budget Committee
Representative Dave Young, Joint Budget Committee
Senator Kevin Grantham, Joint Budget Committee
Senator Pat Steadman, Joint Budget Committee
John Ziegler, Staff Director, JBC
Eric Kurtz, JBC Analyst
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Jed Ziegenhagen, Community Living Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Zach Lynkiewicz, Legislative Liaison, HCPF

# Colorado Medicaid
# Provider Payment Rate Comparison Report

November 1, 2015

# Provider Payment Rate Comparison Report Table of Contents

# 1. Executive Summary

To respond to the FY 2015-16 Legislative Request for Information #1 (LRFI), the Department of Health Care Policy and Financing (Department) contracted with Optumas, an actuarial firm, to assist in comparing Colorado Medicaid's reimbursement rates to the January 2015 Medicare's reimbursement rates or alternative comparable benchmarks. The Department then projected estimates to the FY 2016-17 time period.

The LRFI states that "*Capitated rates, cost-based rates, and rates that are based on a methodology defined in statute shall not be included in the report*", thus the analysis is focused on the following eight categories of service: Practitioner; Durable Medical Equipment/Supplies (DME); Transportation; Dental; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT); Independent Laboratory; Home and Community Based Services (HCBS); Home Health and Private Duty Nursing (HH/PDN). These eight service categories represent approximately one quarter of Colorado Medicaid's total service expenditure for the two fiscal years of data analyzed, FY 2012-13 and FY 2013-14.

The data sources utilized to complete the analysis were: Colorado Medicaid, Medicare, All Payer Claims Database (APCD), other states' Medicaid fee schedules, and an American Dental Association (ADA) survey. Refer to the section "Data Sources" of this report for details.

Analysis of reimbursement rates for Medicaid is a complex exercise that involves an in-depth review of over 12,000 procedure codes in multiple fee schedules with several different payment methodologies by payer (Medicare, APCD, other state's Medicaid programs). Under the Social Security Act, states throughout the country have broad flexibility to establish provider payment rates and payment system models. As a result, some states develop rates based on the cost of providing the service, others reference payments made by commercial payers, and others base rates on a percentage of the Medicare program for equivalent services. Adding to this complexity, discrepancies in elements such as the service unit definition (i.e. a rate per 15 minute vs. a rate per 1 hour unit) across states and Medicare can cause significant variations in rates.

In order to complete a meaningful rate comparison and evaluation of fiscal impact by changing rates, extensive research into Medicare and other states' fee schedules was needed to ensure that the base data was comparable to equivalent rates. For example, California pays for Residential Habilitation at $4.50 per 15 minutes, while Colorado utilizes a per diem rate. Thus, to perform a valid comparison, the Department needed to convert California's rate to a daily rate to compare to Colorado's per-diem rate. This process included an in-depth review of definitions and assumptions pertaining to the services, units, and number of members served in each state's Residential Habilitation benefit to ensure that the conversion was reliable. This level of research was necessary across all services and payers (Medicare, APCD, and other state's Medicaid programs).

Table 1.1 summarizes the estimated Total Fund and General Fund costs/(savings) that would be incurred by the state if rates were set to the specified levels of reimbursement relative to the comparison rates for the different categories of service evaluated in this request[1]. Throughout the report estimates are provided for eight areas of service[2]: Practitioner, DME, Transportation, Dental, EPSDT, Lab, HCBS, and Home Health.

**Table 1.1: FY 2016-17 Estimated Total Funds and General Fund Impact of Utilizing Identified Percentage of Comparison Rates**

| Category of Service | Percentage of Comparison Rate Set | | | |
|---|---|---|---|---|
| | 60% | 75% | 90% | 100% |
| **Practitioner** | ($58,763,306) | $81,244,243 | $221,251,793 | $314,590,160 |
| **DME/Supplies** | ($18,235,442) | ($6,224,298) | $5,786,846 | $13,794,275 |
| **Transportation** | $2,388,403 | $6,794,459 | $11,200,515 | $14,137,886 |
| **Dental** | ($24,768,088) | $22,154,342 | $69,076,772 | $100,358,392 |
| **EPSDT** | ($1,586,864) | ($688,234) | $210,395 | $809,481 |
| **Independent Laboratory** | ($20,522,916) | ($11,898,093) | ($3,273,269) | $2,476,614 |
| **HCBS Waiver** | ($109,557,925) | ($42,252,275) | $25,053,376 | $69,923,810 |
| **Home Health** | ($163,066,193) | ($131,035,848) | ($99,005,504) | ($77,651,940) |
| **Total** | **($394,112,332)** | **($81,905,704)** | **$230,300,924** | **$438,438,677** |
| **Estimated General Fund Impact** | **($170,543,647)** | **($58,343,917)** | **$53,855,811** | **$128,655,631** |

The benchmarks for the rate comparison for Practitioner, DME/Supplies, EPSDT, Independent Laboratory, and Transportation are based on Medicare rates; for procedure codes without a comparable Medicare rate, APCD rates were used.

Dental rates were evaluated using the American Dental Association (ADA) Survey and average reimbursement from other Medicaid agencies[3].

HCBS Waiver and Home Health are services typically not covered by Medicare or private insurance. Consequently, Colorado Medicaid rates for these services can only be compared to other states' Medicaid rates as no other comparison is available. For each benefit, the rates of

[1] As required by the LRFI, the Department created a comprehensive workbook that allows it to set Medicaid rates at different percentages of the comparison rate. The "Medicaid Rate Comparison Tool" partially models the financial impacts by service category. Although this workbook is available upon request, the Department would need to complete additional data removals before sharing to account for Protected Health Information. This additional removal of data would decrease the accuracy of the estimates included in this report.

[2] Refer to Appendix IV for descriptions of the eight areas of service

[3] Nasseh K, Vujicic M, Yarbrough C., *A ten-year, state-by-state, analysis of Medicaid fee-for-service reimbursement rates for dental care services.* Health Policy Institute Research Brief. American Dental Association. October 2014. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_3.ashx.

five states[4] were compared against Colorado's rates. In Table 1.1, the average of the lowest and highest payment rates were used as a benchmark. Table 1.2 provides additional detail by showing the range of costs/(savings) to Colorado from moving payment rates to variable percentages of the highest and lowest comparison state rates.

**Table 1.2: 2016-17 Estimated Total Funds Impact of Utilizing Identified Percentage of High State and Low State Comparison Rates – HCBS and Home Health**

| Service | Benchmark Utilized for Comparison | | Percent of Comparable Rate | | | |
|---|---|---|---|---|---|---|
| | | | 60% | 75% | 90% | 100% |
| HCBS Waiver | State with Lowest Rates | (OH)[1] | ($233,744,018) | ($197,484,891) | ($161,225,763) | ($137,053,012) |
| | State with Highest Rates | (DC) | $14,628,167 | $112,980,341 | $211,332,515 | $276,900,631 |
| | Average High and Low | | ($109,557,925) | ($42,252,275) | $25,053,376 | $69,923,810 |
| Home Health | State with Lowest Rates | (LA) | ($192,194,400) | ($167,446,107) | ($142,697,814) | ($126,198,952) |
| | State with Highest Rates | (NC) | ($133,937,987) | ($94,625,590) | ($55,313,194) | ($29,104,929) |
| | Average High and Low | | ($163,066,193) | ($131,035,848) | ($99,005,504) | ($77,651,940) |

*[1] Of the five states used to compare for each service, the lowest and highest for each service are shown above. For example, Ohio had the lowest total comparison re-priced amount of the five states for which HCBS waiver services were analyzed.*

*Conclusion*

Due to significant variations in the data such as different fees and units across the states, Medicare, APCD and ADA, the results in this report should be further evaluated and discussed for policy applications. The complexities encountered due to the data variations required additional data removals when a comparable rate was not possible to determine. As a result, the figures in the above table and included in the report represent an estimated minimum. An example of this shortcoming is the necessary removal from the analysis of the physician administered drugs for which a comparable rate was not possible to determine at this time. Additional information regarding the data removal is included in the Appendix section of this report. Figures in this report represent the Department's best estimate of expected fiscal impact given historical utilization and caseload trends.

[4] The comparison states for HCBS are District of Columbia, Arizona, Ohio, Illinois, and California. For Home Health they are Idaho, Illinois, Louisiana, North Carolina, and Ohio.

## 2. Rate Comparison Summary

To meet the FY 2015-16 Legislative Requests for Information (LRFI), the Department contracted with Optumas to assist in benchmarking Colorado Medicaid's reimbursement[5]. Specifically, LRFI #1 states:

"*The Department of Health Care Policy and Financing is requested to submit a report to the Joint Budget Committee, by November 1, 2015, comparing Medicaid reimbursement rates for services to Medicare. For codes without a comparable Medicare rate, the Department shall find and identify a data source that will estimate the usual and customary rate paid in a commercial health plan. The Department shall include the reasoning behind the selection of data sources used to estimate the usual and customary rate. The report shall be submitted in a format that provides the ability to estimate the cost of bringing Medicaid rates to a variable percentage of the applicable Medicare rate or usual and customary rate. For codes unique to the Medicaid program, the Department is requested to collect comparable data from other states' Medicaid programs when and if available. For any codes the Department cannot find a comparison rate, the Department shall list the codes, the current Medicaid rate, and the reason the Department was unable to find a comparison. Capitated rates, cost-based rates, and rates that are based on a methodology defined in statute shall not be included in the report.*"

There are 16 tables presented in this section. The tables are organized according to eight services; please see Appendix IV for more details about these services:

- Practitioner[6]
- Home and Community Based Services (HCBS) Waiver
- Home Health (HH)/Private Duty Nursing (PDN)
- Dental
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT)[7]
- Independent Laboratory[8]
- Transportation
- Durable Medical Equipment (DME)/Supplies

For each service, there are two corresponding tables: the first table shows Colorado's rate as a percentage of the comparable rate and, the second table presents the estimated FY 2016-17 impact of setting Medicaid rates at specific percentage levels of the comparable rate.

[5] A portion of the initial work required by the LRFI was reimbursed to the actuarial firm using existing funds from the managed care contract based on ad-hoc hours. Upon authorization, the remaining fraction was reimbursed using C.R.S. 25.5-4-401.5.

[6] Section 1202 of the ACA mandated states to increase a subset of primary care codes to 100% of Medicare for calendar years 2013 and 2014. Colorado will continue this increased payment through June 30, 2016. Fiscal estimates for FY 2016-17 assume the sunset of this policy accordingly. The 1202 codes fall into the practitioner, EPSDT, and Independent Laboratory categories of service, they are rolled together in table 2.1.

[7] Same as footnote 6

[8] Same as footnote 6

This report excludes physician administered drugs[9] from the analysis because when these services were re-priced using the comparable fee for Medicare or the APCD, the outcomes produced large outliers. This is likely the result of unit differences that could not be corrected in a timely basis. Per C.R.S. 25.5-4-401.5, the Department has proposed to review physician administered drugs in year one (fiscal year 2015-16) of the rate review process.

The elements included in the tables are:

**Category of Service** – The particular service that is being compared.

**Service Type** – The subset of services within a particular service. For example, "1202 ACA"[10] is defined in this report as a subset of practitioner services reimbursed at an enhanced rate.

**Colorado as a Percentage of Comparable Rate** – The average unit cost for Colorado Medicaid divided by the average unit cost for the comparable rate. Note that Colorado units are used for weighting only in situations where both Colorado and the applicable comparable have an equivalent fee. This ensures that the comparison can be done on an equivalent basis.

**Estimated Cost/(Savings) to Colorado** – The estimated impact to Colorado to move to a percentage of the comparable rate. It is important to note that ***due to the exclusions mentioned by the LRFI request above as well as instances where the comparable fee does not exist, the estimated impact to Colorado to move to a percentage of the comparable rate may be distorted. The estimated amounts represent a minimum floor when either showing additional costs or savings. If a policy to set rates to a benchmark identified in this report were adopted, the actual costs and/or savings would differ from the amounts shown, as not all services are reflected in this report.***

The Medicare fee schedule includes both a facility and non-facility fee[11]. Because the Colorado Medicaid fee schedule is not facility specific and assumes only non-facility rates, the

[9] "Physician-administered drugs" means drugs other than vaccines covered under section 1927(k)(2) of the Social Security Act that are typically furnished incident to a physician's services

[10] Section 1202 of the Affordable Care Act, set provisions for enhanced payment for primary care services furnished by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine at a rate not less than 100 percent of the payment rate that applies to such services and physician under part B of title XVIII […] Furthermore, section 1202 defines primary care services as ''(1) evaluation and management services that are procedure codes (for services covered under title XVIII) for services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System (established by the Secretary under section 1848(c)(5) as of December 31, 2009, and as subsequently modified); and ''(2) services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such System.''

[11] An example of non-facility setting is the physician's office. A hospital outpatient department is considered a facility setting. Medicare typically pays a physician a higher amount when a service is performed in a non-facility setting.

comparison is to the Medicare non-facility fee. Creating and implementing a facility and non-facility fee schedule could change these results.

Throughout this report the term *comparable rate* means the Medicare rate where applicable and the APCD rate if no Medicare rate exists, or the comparison from other states where applicable. Because these estimates are aggregated to a category of service level, the comparable rate includes both Medicare and the APCD. The Medicaid rate comparison tool includes more information on which procedure codes in each category of service are repriced to Medicare or the APCD.

Costs and differences relative to comparison rates were calculated by the actuarial firm Optumas. These values were then inflated by the Department at the service category level by projected caseload growth through FY 2016-17 (as reported in the FY 2015-16 R-1: "Medical Services Premiums Request" to generate estimated fiscal impacts for FY 2016-17.)

### *Practitioner*[12]

Colorado rates were compared against Medicare and All Payer Claims Database (APCD) when Medicare rates were unavailable as shown in Table 2.1 below.

**Table 2.1**

| Category of Service | Service Type | Colorado as a Percentage of Medicare/APCD Comparable Rates |
|---|---|---|
| Practitioner | Practitioner | 63.0% |
| Practitioner, EPSDT, Independent Laboratory | 1202 ACA | 69.4%(1) |
| Total | | 66.29% |

(1) Rates for 1202 ACA Practitioner are currently at close to 100% of Medicare. However, as of 7/1/2016, rates will be reduced to historic levels. The Department estimates that the entire set of 1202 ACA codes (including EPSDT and Independent Laboratory) will be reimbursed at approximately 69.4% of Medicare.

When practitioner services are compared to Medicare and the APCD (where there are no Medicare comparisons), they fall in the 63%-70% range. This should be interpreted as Colorado ranges from 30% to 37% lower than the comparable rate for practitioner services.
As mentioned above, the fee increase due to Section 1202 of the ACA represented a significant fee increase. Fiscal estimates for FY 2016-17 assume the higher level of reimbursement will sunset 7/1/2016.

[12] Refer to section **5. Methodology** and **Appendix IV** for a description of the practitioner category.

Table 2.2 below combines the separated service types in the practitioner category of service from Table 2.1 above, to provide the estimated cost impact to Colorado for switching to specific percentages of the comparable rate.

**Table 2.2**

| Percentage of Comparable Rate | Estimated Cost/(Savings) to Colorado |
|---|---|
| 60% | ($58,763,306) |
| 75% | $81,244,243 |
| 90% | $221,251,793 |
| 100% | $314,590,160 |

Table 2.2 should be interpreted as an $81.2M cost to Colorado to reimburse practitioners at 75% of the comparable fee. Please note that the fiscal impact for this category includes all codes associated with the 1202 ACA increase, including those for EPSDT services and vaccinations.

### *HCBS Waiver*

As discussed above, Colorado was compared against five states as shown in Table 2.3 below.

**Table 2.3**

| | Colorado as a Percentage of Other States Comparable Rate | | | | |
|---|---|---|---|---|---|
| **Category of Service** | **DC** | **CA** | **AZ** | **IL** | **OH** |
| HCBS Waiver | 57.6% | 69.1% | 94.9% | 125.0% | 140.6% |

The results should be interpreted as Colorado paying approximately 42% lower than District of Columbia and 41% higher than Ohio for waiver services. Note that 66% of the HCBS Waiver paid dollars were associated with Full Benefit Medicare/ Medicaid enrollees, and as mentioned previously, dual eligible members were removed from the analysis. Refer to sections: 3.Scope and Limitations, 5.Methododolgy and Appendix I, II and III for more details on removed services and populations.

Using the re-priced information shown in Table 2.3, the cost impact to Colorado for switching to a percentage of the comparable rate are estimated in Table 2.4 below.

**Table 2.4**

| Service | Benchmark Utilized for Comparison | | Percent of Comparable Rate | | | |
|---|---|---|---|---|---|---|
| | | | 60% | 75% | 90% | 100% |
| HCBS Waiver | State with Lowest Rates | (OH) | ($233,744,018) | ($197,484,891) | ($161,225,763) | ($137,053,012) |
| | State with Highest Rates | (DC) | $14,628,167 | $112,980,341 | $211,332,515 | $276,900,631 |
| | Average High and Low | | ($109,557,925) | ($42,252,275) | $25,053,376 | $69,923,810 |

*Note: Of the five states used to compare for HCBS, the low and high are shown above. For example, Ohio had the lowest total comparison re-priced amount of the five states for which HCBS waiver services were analyzed.*

Table 2.4 should be interpreted as a $197.5M savings to Colorado to reimburse at 75% of Ohio's fee schedule. Conversely, it would cost Colorado approximately $113M if payment was moved to 75% of the District of Columbia's fees for waiver services.

### *Home Health/Private Duty Nursing*

Colorado data rates were compared against five states as shown in Table 2.5 below. Additional relevant information regarding the repricing process for this service category is included in Appendix I(C) of this report.

**Table 2.5**

| | Colorado as a Percentage of Other States Comparable Rate | | | | |
|---|---|---|---|---|---|
| Category of Service | NC | IL | ID | OH | LA |
| HH/PDN | 111.7% | 112.8% | 123.5% | 126.9% | 179.3% |

The results should be interpreted as Colorado paying roughly 12% higher than North Carolina and 79% higher than Louisiana for HH/PDN nursing services.

Using the re-priced information shown in Table 2.5, the cost impact to Colorado for switching to a percentage of the comparable rate are estimated in Table 2.6 below.

**Table 2.6**

| Service | Benchmark Utilized for Comparison | | Percent of Comparable Rate | | | |
|---|---|---|---|---|---|---|
| | | | 60% | 75% | 90% | 100% |
| Home Health | State with Lowest Rates | (LA) | ($192,194,400) | ($167,446,107) | ($142,697,814) | ($126,198,952) |
| | State with Highest Rates | (NC) | ($133,937,987) | ($94,625,590) | ($55,313,194) | ($29,104,929) |
| | Average High and Low | | ($163,066,193) | ($131,035,848) | ($99,005,504) | ($77,651,940) |

*Note: Of the five states used to compare for each Home Health/PDN, the low and high are shown above. For example, Louisiana had the lowest total comparison re-priced amount of the five states for which Home Health services were analyzed.*

Table 2.6 should be interpreted as a $167.5M savings to Colorado to reimburse at 75% of Louisiana's fee schedule. Conversely, Colorado would save approximately $94.6M if payment was moved to 75% of the North Carolina's fees for Home Health services.

### *Dental*

The Department compared Colorado's fees were compared against the weighted average[13] reimbursement of the highest paying Medicaid agencies in the country as a percentage of the American Dental Association (ADA) survey; when no comparable value was available, APCD data was utilized. Results are shown in Table 2.7 below.

**Table 2.7**

| Category of Service | Colorado as a Percentage of ADA/APCD Comparable Rate |
|---|---|
| Dental | 67.9% |

The results can be interpreted as Colorado paying roughly 32% lower than the comparable rate for dental services. Note that the ADA survey[14] reflects charges and not actual payment. Consequently, the average reimbursement from other Medicaid agencies as a percentage of the ADA survey values were utilized[15].

Using the re-priced information shown in Table 2.7, the FY 2016-17 fiscal impact to Colorado for switching to a percentage of the comparable rate is estimated in Table 2.8 below.

**Table 2.8**

[13] The weighted averages included both children's dental services and adult dental services.
[14] Refer to the "Data Sources" section for the ADA survey details.
[15] Nasseh et al., Health Policy Institute Research Brief, 2014.

| Percentage of Comparable Rate | Estimated Cost/(Savings) to Colorado |
|---|---|
| 60% | ($24,768,088) |
| 75% | $22,154,342 |
| 90% | $69,076,772 |
| 100% | $100,358,392 |

In FY 2016-17 as developed by the Department, Table 2.8 should be interpreted as a $22M cost to Colorado to reimburse at 75% of the comparable fee.

### *Early and Periodic Screening, Diagnostic and Treatment*[16]

Colorado was compared against Medicare and APCD as shown in Table 2.9 below.

**Table 2.9**

| Category of Service | Service Type | Colorado as a Percentage of Medicare/APCD Comparable Rate |
|---|---|---|
| EPSDT | Practitioner | 87.6% |

When compared to Medicare and APCD, EPSDT Practitioner claims are close to 88% of the level of reimbursement of the other payers. This can be interpreted as Colorado is 12% lower than the comparable rate for EPSDT services.

Using the re-priced information shown in Table 2.9, the FY 2016-17 fiscal impact to Colorado for switching to a percentage of the comparable rate is estimated in Table 2.10 below.

**Table 2.10**

| Percentage of Comparable Rate | Estimated Cost/(Savings) to Colorado |
|---|---|
| 60% | ($1,586,864) |
| 75% | ($688,234) |
| 90% | $210,395 |
| 100% | $809,481 |

In FY 2016-17 as developed by the Department, Table 2.10 should be interpreted as an approximate $0.7M savings to Colorado to reimburse at 75% of the comparable fee. Please

[16] The subset of codes associated with section 1202 of the ACA under EPSDT are rolled up into the "Practitioner, EPSDT, Independent Laboratory" line on Table 2.1. Please footnotes 6,7, and 8 in the table.

note that EPSDT codes covered under 1202 ACA are included in the practitioner service category impact.

### *Independent Laboratory*

Colorado was compared against Medicare and APCD as shown in Table 2.11 below.

**Table 2.11**

| Category of Service | Service Type | Colorado as a Percentage of Medicare/APCD Comparable Rate |
|---|---|---|
| Independent Laboratory | Practitioner | 93.8% |

When compared to Medicare and APCD, Independent Laboratory claims are approximately 94% of the level of reimbursement of other payers. This can be interpreted as Colorado is 6% lower than the comparable rate for lab services.

Using the re-priced information shown in Table 2.11, the FY 2016-17 fiscal impact to Colorado for switching to a percentage of the comparable rate is estimated in Table 2.12 below. Please note that Independent Laboratory codes covered under 1202 ACA are included in the practitioner service category impact.

**Table 2.12**

| Percentage of Comparable Rate | Estimated Cost/(Savings) to Colorado |
|---|---|
| 60% | ($20,522,916) |
| 75% | ($11,898,093) |
| 90% | ($3,273,269) |
| 100% | $2,476,614 |

In FY 2016-17 as developed by the Department, Table 2.12 can be interpreted as an $11.9M savings to Colorado to reimburse at 75% of the comparable fee.

### *Transportation*

Colorado was compared against Medicare and APCD as shown in Table 2.13 below.

**Table 2.13**

| Category of Service | Colorado as a Percentage of Medicare/APCD Comparable Rate |
|---|---|
| Transportation | 51.8% |

The results can be interpreted as Colorado paying roughly 48% lower than the comparable rate for transportation services. It should be noted that the Medicare fees for ambulance services are significantly higher than Medicaid, which is what drives the results in Table 2.13. APCD was only used to re-price less than 9% of the total comparable dollars.

Using the re-priced information shown in Table 2.13, the FY 2016-17 fiscal impact to Colorado for switching to a percentage of the comparable rate are estimated in in Table 2.14 below.

**Table 2.14**

| Percentage of Comparable Rate | Estimated Cost/(Savings) to Colorado |
|---|---|
| 60% | $2,388,403 |
| 75% | $6,794,459 |
| 90% | $11,200,515 |
| 100% | $14,137,886 |

In FY 2016-17 as developed by the Department, Table 2.14 can be interpreted as a $6.8M cost to Colorado to reimburse at 75% of the comparable fee.

### *Durable Medical Equipment/Supplies*

Colorado was compared against Medicare and APCD as shown in Table 2.15 below.

**Table 2.15**

| Category of Service | Colorado as a Percentage of Medicare Comparable Rate |
|---|---|
| DME/Supplies | 81.7% |

The results can be interpreted as Colorado paying approximately 18% lower than the comparable rate for DME/Supplies services. APCD was not used to re-price the DME/Supplies claims. When the APCD data was used for re-pricing in situations where a Medicare fee was not available, the results appeared unreasonable and were thus removed. Additional research indicated that there may be inconsistencies with reported units in the Medicaid base data compared to APCD.

Using the re-priced information shown in Table 2.15, the FY 2016-17 fiscal impact to Colorado for switching to a percentage of the comparable rate are estimated in in Table 2.16 below.

**Table 2.16**

| Percentage of Comparable Rate | Estimated Cost/(Savings) to Colorado |
|---|---|
| 60% | ($18,235,442) |
| 75% | ($6,224,298) |
| 90% | $5,786,846 |
| 100% | $13,794,275 |

In FY 2016-17 as developed by the Department, Table 2.16 can be interpreted as a $6.2M savings to Colorado to reimburse at 75% of the comparable fee.

## 3. Scope and Limitations

The intent of this report is to respond to LRFI #1 by: a) evaluating Colorado Medicaid rates to an appropriate comparable rate and, b) modeling the estimated impact to Colorado Medicaid by moving to a percentage of the comparable rate. To ensure that the figures in this report are not taken out of context, the following caveats are important to note:

- Although comparing rates across different payers can be easily accomplished in some cases there are situations in which a comparison requires significant more effort. For example:
  - Evaluation and Management (E&M) codes have clearly defined units which are widely accepted across the health care industry. This means that rates from different payers can easily be compared.
  - Certain chemotherapy drugs had extreme variations between the Colorado and Medicare fee schedules. This is because Medicare no longer pays for these drugs using a fee schedule methodology but the rates are still shown on the fee schedule.
  - Medicare bundles certain lab procedure codes in such a way that it appears that Medicare pays more than Colorado. However, this is only because Colorado pays for each procedure separately and Medicare assumes multiple procedures are performed each time a code is billed.
- The LRFI defined "exclusions" as "*Capitated rates, cost-based rates, and rates that are based on a methodology defined in statute shall not be included in the report*". Payment for services for FY 2013-14 totaled $4,581,754,618. For that period, the portion of the "excluded" categories referred by the LRFI request to the total payment represent approximately 64.5% of total payments.
- The analysis presented in this report is based on FY 2012-13 and FY 2013-14 data. The intention was to include as much information as possible to account for the expansion population and for sufficient utilization for re-pricing calculation.
- The eight services included in this companion report represent approximately 35.5% of total Medicaid spending in FY 2013-14. When estimates are given for the cost to Colorado Medicaid to move to a percentage of the comparable rate, the reader is cautioned to keep this in mind. Although LRFI #1 delimited the scope of the analysis to the eight categories included in this report, this study shows how complex comparison of provider rates could be.
- Additional to the exclusions defined above by the LRFI #1, further data could not be included in the analysis. This consideration is defined as data "removed". An example of data removed is Full Benefit Medicare/Medicaid Enrollees. For a list of removals, refer to Appendices I, II and III of this report.
- When comparing Colorado Medicaid to other states, cost of living was not factored into the comparison. For instance, differences in HCBS Medicaid rates across states are impacted by significant differences in wages, and price of inputs. Consideration to cost of living variances across states may provide a more robust analysis regarding fee differences.
- Total payment amounts made by Medicare or by other states as well as utilization data for the services evaluated are not included in this companion report. This additional

information could reflect similar payment and utilization for comparable services despite rate differences.

- The fiscal impacts included in the Tables 1.1 and 6.1 are shown in Total and General Funds. Depending on the service category, variations of federal matching funds are available and therefore the fiscal impact to the state is expected to be smaller.
- The dollar impacts listed throughout the document were calculated by using FY 2012-13 and FY 2013-14 data and adjusted for utilization and caseload trends by the Department.
- Due to the exclusions mentioned by the LRFI request as well as instances where the comparable fee does not exist, the estimated impact to Colorado to move to a percentage of the comparable rate may be distorted. The estimated amounts represent a minimum floor when either showing additional costs or savings. If a policy to set rates to a benchmark identified in this report were adopted, the actual costs and/or savings would differ from the amounts shown, as not all services are reflected in this report. Figures in this report represent the Department's best estimate of expected fiscal impact given historical utilization and caseload trends.

# 4. Data Sources

### *Medicaid*

Utilizing the Medicaid fee-for-service claims data spanning FY 2012-13 and FY 2013-14, checks on volume and dollar amounts were completed across time to identify inconsistencies in the data. A frequency analysis on the various fields was also performed to fully account for the contents of the claims. Additionally, the data was validated against Colorado's corresponding fiscal expenditure reports[17]. Services such as dental, EPSDT, and independent laboratory compared very close to the expenditure reports.

### *Medicare*

To re-price the Colorado Medicaid data on a detailed claims level the CY2015 Medicare Physician fee schedule, Average Sales Price (ASP) Drug Pricing File, the Clinical Diagnostic Laboratory fee schedule, Durable Medical Equipment fee schedule (DMEPOS), Anesthesia Base Current Procedural Terminology (CPT) Units, and Anesthesia Conversion Factors[18] were utilized to facilitate direct payment comparisons.

### *All Payer Claims Database*

The Department coordinated with the Center for Improving Value in Health Care (CIVHC) to obtain the All Payer Claims Database (APCD). The APCD database contain claims data for commercial health plans, Medicare and Medicaid. Per the LRFI, the APCD was used to re-price Colorado Medicaid data in cases where a comparable Medicare rate does not exist. Examples include certain contraceptive systems and well-child visits. CIVHC provided the APCD for FY 2012-13 and FY 2013-14, which reflected the latest data readily available. The data was validated through high level volume and dollar checks to ensure that it was consistent over time.

### *Other States' Medicaid Fee Schedules*

As described in the LRFI #1, the analysis should use other states' Medicaid fee schedules for codes or services that are unique to Medicaid. The Rate Comparison Summary section explained how other states' Medicaid fee schedules were applied to re-price HCBS waiver and HH/PDN claims. Publicly available fee schedule information was employed for the District of Columbia and the states of Arizona, California, Idaho, Illinois, Louisiana, Ohio and North Carolina.

### *American Dental Association (ADA) Survey*

With no Medicare fee schedule available, dental claims were re-priced using the results of the most recent ADA survey. The ADA survey of fees includes data from a nationwide random sample of dentists who are asked to provide the fee most often charged for most commonly performed dental procedures.

[17] https://www.colorado.gov/pacific/hcpf/premiums-expenditures-and-caseload-reports
[18] https://www.cms.gov

## 5. Methodology

The first step in the analysis involved re-pricing the FY 2012-13 and FY 2013-14 Colorado Medicaid data to the January 1, 2015 Colorado fee schedule. This adjustment was necessary to set the baseline data to the most recent reimbursement fee schedule available.

Given the wide variety of payment methodologies in use by states and certain services, some general assumptions had to be adopted for the comparison analysis:

- Full Benefit Medicare/Medicaid Enrollees (FBMME) as well as members with commercial insurance coverage were removed. Per Federal regulation, all available health insurance benefits shall be applied to payment before Medicaid. Thus, claims that include a third party insurance payment usually reflect only the remaining unpaid portion. Given time and budget constraints, the process of updating the relevant Medicare rates and re-calculating Medicaid's responsibility was deemed to be too complex.
    - Though the overall impact was small (the magnitude varies by service), some claims that were **not** removed with FBMME beneficiaries or members with commercial insurance coverage still included a third party liability (TPL) amount. In these situations, the TPL dollars were reduced from the re-priced Medicaid, Medicare, and other states' comparable amounts. This only affected the cost/(savings) dollar tables shown in Section 2.
- Copayments for FY 2012-13 and FY 2013-14 were assumed to be unchanged as of January 1, 2015. This is critical because copayments reduce the total amount paid by Medicaid. Furthermore, the LRFI specifically requests that the report estimate the cost of moving to a variable percentage of the comparable rate, which requires that copayments be taken into consideration.
- Colorado Medicaid utilizes a claim adjudication system that compares submitted charges to the amount calculated using the Medicaid fee schedule and pays according to whichever is lower. The data included a field called Line Reimbursement Status Code that distinguishes between the two outcomes. Claims with a "Billed Charge" line reimbursement status indicate that the provider's submitted charges were lower in that instance. Given more time and resources, a sensitivity test would be completed for the claims that reimbursed at a lower charge under multiple approaches.
- Claims that did not generate a payment were removed from the analysis. These claims did not affect total payment, thus their inclusion would distort the estimated cost of moving to the comparable rate.
- Claims that do not have an eligible span within the enrollment data were removed for the analysis. This represents less than 1% of paid claims and is comparable to data from other states.
- Per the LRFI, any service that involved cost-based payment, capitation and rates that are based on a methodology defined in statute were excluded from this analysis. These include inpatient, most outpatient, nursing facility, pharmacy, Federally Qualified Health Centers

(FQHC), and Rural Health Clinic (RHC) services. Additionally, please refer to Appendix I, II and III for a list of removals by service.

- The Medicaid data included the following key financial fields: billed amount, allowed charges, paid amount, copay amount and TPL amount.
  In Section 2, tables 2.1, 2.3, 2.5, 2.7, 2.9, 2.11, 2.13, and 2.15 show the Colorado Medicaid January 1, 2015 average fee compared against the average fee of Medicare, APCD, and/or other states' Medicaid.[19] To estimate the overall average fee for a given service, the units in the data were used as weights only in situations where both Colorado Medicaid and the applicable rate have a comparable fee. For example, assume that the following four codes exist for a particular service (numbers are for illustration only):

**Table 5.1**

| Procedure Code | CO Medicaid Utilization | CO Medicaid 1/1/15 Fee | Comparable Fee |
|---|---|---|---|
| 99201 | 100 | $120.00 | |
| 99202 | 100 | | $170.00 |
| 99203 | 100 | $105.00 | $125.00 |
| 99204 | 100 | $110.00 | $127.00 |
| Weighted Average fee using all utilization | | $83.75 | $105.50 |
| Weighted Average fee using utilization in situations only where both Colorado and the comparable fee have rates | | $107.50 | $126.00 |

  In this example, procedure codes 99201 and 99202 do not have a fee for both Colorado Medicaid and the comparable rate, meaning that the utilization for those codes would not be used to develop the average fee.
- In Section 2, Tables 2.2, 2.4, 2.6, 2.8, 2.10, 2.12, 2.14, and 2.16 detail the cost/(savings) to Colorado if the rates were to move to the relevant comparable rate. The estimated impact is calculated as the difference between the Colorado Medicaid January 1, 2015 average fee[20] less the comparable rate average fee multiplied by the Colorado Medicaid units. Copayments and TPL amounts from the data are then reduced to estimate the total impact to Colorado.
- When a single comparable rate was potentially applicable to a range of Colorado Medicaid rates, further research was completed to find the one that best matched the services in question. If results were not conclusive, an average was used.
- The determination of the service unit definition was a complex task that required an intense use of resources. It was not uncommon for it to vary between the Department's fee schedules, Medicare, and other states. When a clear definition was available, comparable conversions were done to complete the re-pricing.

The following sections provide more details for each category of service. Additional information of each program is included in Appendix IV of this companion report.

[19] With the exception of the 1202 ACA codes, which reflect historical pricing due to the policy sunset in FY2016-17.
[20] With the exception of the 1202 ACA codes, which reflect historical pricing due to the policy sunset in FY2016-17.

### *Practitioner*

Colorado Medicaid pays for practitioner services on a unit of service basis by procedure code. The practitioner service was initially split into three categories. The first category named *Section 1202 of the ACA*, which includes the typical Evaluation and Management (E&M) codes (99201-99499) as well as vaccine administration codes (90460, 90461, 90471-90474). The second category named *physician administered drugs* (see Appendix II for a complete listing of these codes)[21]. The last category includes all practitioner codes not captured in the previous two and is simply labeled "*Practitioner*".

There are several items that should be noted regarding the practitioner re-pricing contained in this report:

- The Medicare fee schedule includes facility and non-facility fees. The re-pricing analysis initially included two scenarios: apply the non-facility fee to all claims regardless of place of service or apply the fee that corresponds to the place of service in the data. However, because the Colorado Medicaid fee schedule contains only non-facility rates, the corresponding Medicare fees were used.[22]
- To re-price anesthesia, the following formula was used: (Base Value + Number of 15-minute increments) * Conversion Factor.
- There were some procedure codes that existed in the base data that have since been deleted. The MMIS data indicated which new procedure codes to use in place of the base data procedure codes when re-pricing to the January 1, 2015 fee schedule.
- Vaccines for Children (VFC) procedure codes with ages less than or equal to 18 years have been removed from the base data. These claims are federally paid, and contain only the administrative fee. For list of procedure codes, see the Immunization Benefit Manual.[23]
- The APCD was utilized in situations where Medicare does not have a comparable fee to Medicaid. APCD was used to re-price less than 2% of the total January 1, 2015 Medicaid dollars.
- Medicare pays a reduced fee in situations involving multiple procedures and therapies. The Medicare figures will be somewhat overstated because the reduced fee was not incorporated in the analysis. Accounting for this variation adds considerable complexity to the re-pricing and given more time and resources this could be revisited at a later date.
- When re-pricing the physician administered drugs using Medicare or APCD large outliers resulted. Further analysis showed that the base units were different between the schedules or a comparison could not be completed due to lack of information. Correcting for the unit differences is complex and requires a significant amount of resources. This task could not be

[21] This group had to be removed from the analysis due to data unreliability.

[22] The split between a facility and non-facility fee is available upon request. If such split would be adopted, changes to the claims processing system should be made to account for it.

[23] https://www.colorado.gov/pacific/sites/default/files/CMS1500_Immunization_1.pdf

corrected in a timely basis and a decision was made to proceed with removing the physician administered drugs from the analysis.[24]

### *HCBS Waiver*

Colorado Medicaid pays for HCBS waiver services on a unit of service basis by procedure code. The unit of service is typically 15-minute increments, half day, per day, or per trip.

There are several items that should be noted regarding the HCBS[25] waiver re-pricing contained in this report:

- Codes that were missing on the Colorado Medicaid fee schedule were removed from the analysis. See Appendix I(B) and Appendix III for more information regarding removed codes.
- Some of the codes are priced with negotiated rates, multiple rates by vendor, or Public Utility Commission (PUC) determined rates. Procedure codes with negotiated rates or with multiple rates by vendor were removed. For PUC rates, it was assumed that the current rate has not changed from the historical data. Therefore, the re-priced amount was made equal to the paid amount.
- Some of the codes and modifiers were no longer in use and removed from this analysis.

Once the Medicaid data was re-priced using the January 1, 2015 fee schedule, the following states/Districts were identified as having publicly available HCBS waiver information to use for comparing: Arizona, California, District of Columbia, Illinois and Ohio. For all states except Arizona, Appendix J from the 1915(c) waiver[26] application was utilized to re-price the data by waiver service. District of Columbia's level benefits were reviewed and a crosswalk mapping the District of Columbia Residential Habilitation Levels to Colorado's Levels was developed. Arizona operates an 1115 waiver, which does not include Appendix J data, thus detailed waiver fees that are publicly available were used.

- The District of Columbia pays using five level rates from lower to higher acuity level (Level 1 through Level 5 rates), while Colorado reimburses using seven levels and corresponding rates. District of Columbia's support level benefits were reviewed to develop a crosswalk mapping District of Columbia Residential Habilitation 4 person support levels to Colorado's residential habilitation levels 1 through 7. While Colorado's January 1, 2015 average unit cost for residential habilitation is $148.63, when applying the more specific level rates for District of Columbia, the average unit cost with Colorado's utilization increased to $379.91. This discrepancy is a key contributing factor as to why the overall District of Columbia comparable rate is so much higher than Colorado.

[24] The Department proposed a complete rate review to physician administered drugs (J Codes) during December 2015-May 2016 addressing C.R.S. 25.5-4-401.5

[25] The Department proposed a rate review for HCBS services during June 2016-May 2017 addressing CRS 25.5-4-401.5

[26] The Medicaid HCBS waiver program is authorized under Section 1915 (c) of the Social Security Act. States can assist Medicaid beneficiaries by providing a wide array of services that permit them to live in their homes or community and avoid institutionalization in a nursing home facility.

- Appendix J information is an "average unit cost". California's Appendix J reported Residential Habilitation at $4.50 per 15-minutes, while Colorado identifies a per diem rate. Thus, 12-hours per day was assumed, resulting in a $216 per-diem.
- Arizona did not have a 1915(c) available – thus publically available rates[27] were used. The document lists the level specific residential habilitation rates for one resident. There are 20 levels of rates which do not cleanly align with the seven levels of rates for Colorado. The level 1 rate of $153.43 was utilized for all levels of Colorado residential habilitation.
- Payment for Colorado's HCBS Transportation is based on mileage bands, while other states' listed transportation as a per-mile or per trip basis; thus, HCBS transportation was not included in the analysis.
- Only sub-categories of service that had both a Medicaid re-priced amount and a corresponding rate in at least one of the other states were included in this analysis.

### *Home Health/Private Duty Nursing*

Colorado Medicaid pays for HH/PDN services on a unit of service basis by revenue code. The HH units of service are typically either 15-minute increments or single visits. The PDN unit of service is an hour.

There are several items that should be noted regarding the HH/PDN[28] re-pricing contained in this report:

- Colorado Medicaid pays the home health aide service (revenue codes 0570-0572, 0579) with a basic rate for one hour and a 15-30 minute unit extended rate for visits lasting more than one hour. Four out of the five states compared did not have an extended rate for visits lasting more than one hour.
- Once the Colorado Medicaid data was re-priced using the January 1, 2015 fee schedule, the following states were identified as having publicly available fee schedule information to use for comparison: Idaho, Illinois, Louisiana, North Carolina, and Ohio.
- When hospice services were re-priced to the Colorado Medicaid January 1, 2015 fee schedule, revenue codes and provider IDs were used to assign a rate to each individual claim. This process was not possible when comparing the hospice services to other states because the states' publicly available rates were broken down by county. The average service rate across counties in each state was calculated and utilized for comparison re-pricing.

[27] https://www.azdes.gov/uploadedFiles/Developmental_Disabilities/ddd_ratebook_2014.pdf

[28] The Department proposed a rate review for HH/PDN services during December 2015-May 2016 addressing C.R.S. 25.5-4-401.5

### *Dental*

Colorado Medicaid pays for dental services on a unit of service basis by procedure code. The dental procedure codes range from D0100-D9999.

There are several items that should be noted regarding the dental re-pricing contained in this report:

- The 2013 American Dental Association (ADA) Survey was used as a comparable rate. Traditional Medicare provides a limited dental benefit and the APCD includes very limited dental experience. Therefore the average fee from the 2013 ADA Survey was used to compare against Colorado Medicaid. Although 91% of the paid Medicaid dollars were re-priced with the 2013 ADA Survey, where there was no match, the APCD Commercial data was utilized for comparison.
- Regarding the national average fee used from the 2013 ADA survey, the survey question asks "record the actual fee amount that you most often **charge**, not the portion of your charge which you expect to receive or for which you might be reimbursed". Therefore it is possible that the fees in the survey are more representative of billed charges rather than allowed fees. Self-reporting bias could be an issue to consider given that only a fraction of the surveys sent received a response.
- Colorado's fees were compared against the weighted average reimbursement of the highest paying Medicaid agencies in the country as a percentage of the American Dental Association (ADA) survey.[29]
- It is also important to note that the Colorado Adult Dental Medicaid Benefit has a $1,000 cap on all services. An increase in the rates to the comparable rate, would decrease the amount of services available to members. The cost impact estimates shown in Table 2.8 assume no cap to the benefit.

### *Early and Periodic Screening, Diagnostic and Treatment*

Colorado Medicaid pays for EPSDT services on a unit of service basis by procedure code. The Medicaid data included an EPSDT category of service which was used to identify the appropriate claims for re-pricing.

There are several items that should be noted regarding the EPSDT re-pricing contained in this report:

- The APCD was used in situations where Medicare does not have a comparable fee to Medicaid. Since Medicare does not cover many of the EPSDT codes (such as Well Child Visits), the APCD was used to re-price 63% of the total comparable dollars.
- Similar to the practitioner service, when re-pricing using the Medicare fee schedule the non-facility fees were used.

[29] Nasseh et al., Health Policy Institute Research Brief, 2014.

### *Independent Laboratory*

Colorado Medicaid pays for independent laboratory services on a unit of service basis by procedure code. The Medicaid data included an independent laboratory category of service which was used to identify the appropriate claims for re-pricing.

There are several items that should be noted regarding the independent laboratory[30] re-pricing contained in this report:

- The APCD was used in situations where Medicare does not have a comparable fee to Medicaid. The APCD was used to re-price less than 11% of the total paid Medicaid dollars.
- Similar to the practitioner service, when re-pricing using the Medicare fee schedule the non-facility fees were used.
- There were some procedure codes that existed in the base data that have since been deleted. The MMIS data indicated which new procedure codes to use in place of the base data procedure codes when re-pricing to the January 1, 2015 fee schedule. Specifically, procedure code 87624 (HPV screening) was used as replacement for the deleted code 87621.
- In instances where comparable rate re-pricing did not seem reasonable, additional research was done to identify differences in payment. For example, procedure code G0434 (non-chromatographic drug screening) was utilized in place of G0431 for Medicare re-pricing due to payment methodology differences.

### *Transportation*

Colorado Medicaid pays for transportation services on a unit of service basis by procedure code. The unit of service is typically on a per-trip or per mile basis.

There are several items that should be noted regarding the transportation[31] re-pricing contained in this report:

- The APCD was utilized in situations where Medicare does not have a comparable fee to Medicaid. The APCD data was used to re-price less than 12% of the total comparable dollars.
- Medicare fees are significantly higher than Medicaid. The Medicare methodology accounts for rural/urban and mileage differences that the Department's rates do not take into consideration. The decision was made to proceed with the analysis even though Medicare is significantly higher than Medicaid for this particular service.
- The NEMT Medicaid fee schedule did not contain rates for procedure codes A0110 (non-emergency bus transportation), A0140 (non-emergency air travel) and A0999 (unlisted ambulance service). These codes were assumed to be similar to the PUC codes, thus the re-priced amount is equal to the paid amount.

[30] The Department proposed a rate review for laboratory services during December 2015-May 2016 addressing C.R.S. 25.5-4-401.5. It is also relevant to note that CMS issued a proposed rule to reduce payment for laboratory services by using average commercial payment rates.

[31] The Department proposed a rate review for transportation during December 2015-May 2016 addressing C.R.S. 25.5-4-401.5.

- The Medicaid transportation claims did not include the Denver region for FY 2013-14, as Denver Metro area utilizes a transportation broker the fee-for-service claims were paid through invoicing and do not exist in the MMIS system.

### *Durable Medical Equipment/Supplies*

Colorado Medicaid pays for DME/supplies services on a unit of service basis by procedure code. The unit of service varies depending on the procedure code.

There are several items that should be noted regarding the DME/supplies re-pricing contained in this report:

- For those instances where comparable rate re-pricing did not seem reasonable, additional research was done to identify differences in payment. Procedure code E1390 (oxygen concentrator) with the TT modifier was an extreme outlier that was unable to be reconciled, and so it was removed from the analysis.
- The APCD data was analyzed for situations where a Medicare fee was not available, but was not included in this analysis because there seemed to be inconsistencies in reporting units, resulting in erroneous re-priced amounts. Given more time and resources, this may be reviewed at a later date.

## 6. Conclusions/Recommendations

Analysis of reimbursement rates is a complex exercise. Discrepancies in elements such as the definition of the service unit across states and Medicare, could cause significant variations in rates. All efforts were made to ensure that rates were defined on a comparable basis.

The summary Table 6.1 (copied from Table 1.1 of section 1) below shows the results of the analysis:

**Table 6.1 FY 2016-17 Estimated Total Funds and General Fund Impact of Utilizing Identified Percentage of Comparison Rates**

| Category of Service | Percentage of Comparison Rate Set | | | |
|---|---|---|---|---|
| | 60% | 75% | 90% | 100% |
| **Practitioner** | ($58,763,306) | $81,244,243 | $221,251,793 | $314,590,160 |
| **Durable Medical Equipment** | ($18,235,442) | ($6,224,298) | $5,786,846 | $13,794,275 |
| **Transportation** | $2,388,403 | $6,794,459 | $11,200,515 | $14,137,886 |
| **Dental** | ($24,768,088) | $22,154,342 | $69,076,772 | $100,358,392 |
| **EPSDT** | ($1,586,864) | ($688,234) | $210,395 | $809,481 |
| **Lab** | ($20,522,916) | ($11,898,093) | ($3,273,269) | $2,476,614 |
| **HCBS** | ($109,557,925) | ($42,252,275) | $25,053,376 | $69,923,810 |
| **Home Health** | ($163,066,193) | ($131,035,848) | ($99,005,504) | ($77,651,940) |

| | | | | |
|---|---|---|---|---|
| **Total** | **($394,112,332)** | **($81,905,704)** | **$230,300,924** | **$438,438,677** |
| **Estimated General Fund Impact** | **($170,543,647)** | **($58,343,917)** | **$53,855,811** | **$128,655,631** |

As shown in Appendices I-III and discussed throughout the document, there were instances in which some of the data was removed due to time constraints as well as apparent unit of service issues. A good example is the physician administered drugs in which the results were not reasonable and therefore had to be removed. If given more time to research, this issue could be resolved or another comparable rate, such as other states' Medicaid fee schedules, may be utilized.

Table 6.2 shows each service as well as refinements that could be implemented in the future to improve the analysis:

**Table 6.2**

| Category of Service | Future Comparison Refinements |
|---|---|
| Practitioner | Additional analysis around the physician administered drugs may include using other states' Medicaid fee schedule for comparison. |
| HCBS Waiver | Additional discussions with other states to obtain better pricing information. |
| HH/PDN | Rather than using a county-wide average from other states, designating counties as urban or rural allow the application of regional data for a more accurate comparison. |
| Dental | ADA Survey represents charges and not reimbursement rates, obtaining other states' Medicaid fee schedules or more robust APCD data may represent a better comparable rate. |
| EPSDT | Additional analysis around the physician administered drugs may include using other states' Medicaid fee schedule for comparison. |
| Independent Laboratory | Additional analysis around the physician administered drugs may include using other states' Medicaid fee schedule for comparison. |
| Transportation | The Medicaid transportation claims did not include the Denver Metro area for FY 2013-14. As the Denver region used a transportation broker, thus the fee-for-service claims do not exist in the MMIS system. It would be beneficial to include this utilization in the future. |
| DME/Supplies | There seemed to be inconsistencies in the fee schedules reporting units, resulting in erroneous re-priced amounts. Additional discussions with other states to obtain better pricing information. |

Other general improvements to the methodology that are not service specific could be:

- Obtain more recent data so that it captures more than six months of Medicaid Expansion.
- Implement a utilization trend component to the analysis to reflect the fact that the Medicaid populations tend to use more services over time.
- A cost of living adjustment could be factored into the analysis when comparing to other states.
- The Colorado Medicaid data includes a field called Line Reimbursement Status Code. Claim lines with a "Billed Charge" line reimbursement status indicate that the provider billed less than the Medicaid fee schedule. Given more time and resources, a sensitivity test could be completed for these claims under multiple approaches.
- Conduct further research into the physician administered drugs to gain a better understanding of the unit differences across the data sources. This may include using other states' Medicaid fee schedules as an additional comparable rate.
- In instances where a comparable Medicare or APCD fee is not available, use of other states' fee schedules may be used to apply a comparable rate.
- This report does not include a comparison of total payment amounts between Medicare, other states and commercial payers for the included services. Also, this report does not include a comparison of utilization of services between Medicare, other states and commercial payers. These types of analysis are out of scope of the work for this report.
- It is also important to know that although Colorado's rates may be low in specific programs areas, payments for these specific program services are comparable given the utilization patterns.
- Medicare pays a reduced fee in situations involving multiple procedures and therapies. The Medicare figures will be somewhat overstated because the reduced fee was not incorporated in the analysis.

# 7. Appendices

## Appendix I(A) – Summary Data by Service

| | Practitioner | Dental | EPSDT | Independent Laboratory | Transportation | DME/Supplies |
|---|---|---|---|---|---|---|
| **FY2012-13 & FY2013-14 Base Data** | **$ 740,007,789** | **$ 264,602,563** | **$ 48,323,430** | **$ 64,827,200** | **$ 25,101,504** | **$ 226,514,082** |
| **Removed** | | | | | | |
| No Eligibility Span | $ 7,884,429 | $ 1,704,687 | $ 334,668 | $ 790,567 | $ 221,685 | $ 1,303,744 |
| Dual | $ 3,714,993 | $ 6,065,446 | $ 13,057 | $ 263,831 | $ 5,383,616 | $ 53,660,367 |
| Commercial Insurance Coverage | $ 24,687,477 | $ 7,923,148 | $ 873,735 | $ 2,197,161 | $ 497,735 | $ 10,386,809 |
| FQHC, RHC, and School-Based Clinic | $ 6,999,411 | $ - | $ - | $ - | $ - | $ - |
| Code is Manually Priced | $ 5,283,480 | $ - | $ 132 | $ 27,375 | $ - | $ - |
| Vaccines for Children | $ 7,387 | $ - | $ 3,789 | $ - | $ - | $ - |
| Not a Medicaid Benefit | $ 646,599 | $ - | $ 1,289 | $ 87 | $ - | $ - |
| No Fee Available | $ 4,465,711 | $ 712 | $ 84,695 | $ 6,694,706 | $ - | $ 16,396,925 |
| Zero Paid | $ - | $ - | $ - | $ - | $ - | $ - |
| Zero Repriced | $ 863 | $ 2,874,736 | $ 7 | $ - | $ - | $ 328,173 |
| **Total Removed** | **$ 53,690,350** | **$ 18,568,729** | **$ 1,311,370** | **$ 9,973,728** | **$ 6,103,036** | **$ 82,076,018** |
| **Total Base Medicaid Data to Re-Price** | **$ 686,317,440** | **$ 246,033,833** | **$ 47,012,060** | **$ 54,853,472** | **$ 18,998,468** | **$ 144,438,064** |
| **Total Base Medicaid Data Re-Priced to Jan 2015 Rates** | **$ 844,792,594** | **$ 259,425,148** | **$ 68,673,448** | **$ 58,190,334** | **$ 21,343,618** | **$ 160,068,640** |
| **Total Medicaid Jan 2015 Rates where Comparable Rate Exists** | **$ 768,656,372** | **$ 242,124,474** | **$ 68,074,937** | **$ 54,153,667** | **$ 16,297,066** | **$ 81,776,838** |
| **Total Comparable Rate** | **$ 979,955,319** | **$ 497,174,225** | **$ 77,462,207** | **$ 57,723,512** | **$ 31,486,251** | **$ 100,141,366** |

***Note that due to the exclusions as well as removals and instances where a comparable rate does not exist, the estimated impact to Colorado of moving to a percentage of the Comparable Rate is distorted. In addition, dollars are estimated using FY2012-13 and FY2013-14 utilization, which will likely be lower than the current utilization.***

## Appendix I(B) – Summary Data for HCBS Waiver

| | DC | CA | AZ | IL | OH |
|---|---|---|---|---|---|
| **FY2012-13 & FY2013-14 Base Data** | **$ 1,361,086,522** | **$ 1,361,086,522** | **$ 1,361,086,522** | **$ 1,361,086,522** | **$ 1,361,086,522** |
| **Removed** | | | | | |
| No Eligibility Span | $ 4,567,039 | $ 4,567,039 | $ 4,567,039 | $ 4,567,039 | $ 4,567,039 |
| Dual | $ 904,367,822 | $ 904,367,822 | $ 904,367,822 | $ 904,367,822 | $ 904,367,822 |
| Commercial Insurance Coverage | $ 44,688,074 | $ 44,688,074 | $ 44,688,074 | $ 44,688,074 | $ 44,688,074 |
| Negotiated Rates | $ 22,906,425 | $ 22,906,425 | $ 22,906,425 | $ 22,906,425 | $ 22,906,425 |
| Duplicated Rates | $ 45,272,652 | $ 45,272,652 | $ 45,272,652 | $ 45,272,652 | $ 45,272,652 |
| No Fee Available | $ 50,555 | $ 50,555 | $ 50,555 | $ 50,555 | $ 50,555 |
| Zero Paid | $ - | $ - | $ - | $ - | $ - |
| Zero Repriced | $ 106,679 | $ 106,679 | $ 106,679 | $ 106,679 | $ 106,679 |
| **Total Removed** | **$ 1,021,959,247** | **$ 1,021,959,247** | **$ 1,021,959,247** | **$ 1,021,959,247** | **$ 1,021,959,247** |
| **Total Base Medicaid Data to Re-Price** | **$ 339,127,275** | **$ 339,127,275** | **$ 339,127,275** | **$ 339,127,275** | **$ 339,127,275** |
| **Total Base Medicaid Data Re-Priced to Jan 2015 Rates** | **$ 355,073,863** | **$ 355,073,863** | **$ 355,073,863** | **$ 355,073,863** | **$ 355,073,863** |
| **Total Medicaid Jan 2015 Rates where Comparable Rate Exists** | **$ 284,771,916** | **$ 305,690,958** | **$ 264,409,503** | **$ 301,359,464** | **$ 282,360,776** |
| **Total Comparable Rate** | **$ 494,781,857** | **$ 442,433,700** | **$ 278,595,974** | **$ 241,062,529** | **$ 200,785,718** |

***Note that due to the exclusions as well as removals and instances where a comparable rate does not exist, the estimated impact to Colorado of moving to a percentage of the Comparable Rate is distorted. In addition, dollars are estimated using FY2012-13 and FY2013-14 utilization, which will likely be lower than the current utilization.***

## Appendix I(C) – Summary Data for Home Health/Private Duty Nursing

| | NC | IL | ID | OH | LA |
|---|---|---|---|---|---|
| **FY2012-13 & FY2013-14 Base Data** | **$ 566,140,525** | **$ 566,140,525** | **$ 566,140,525** | **$ 566,140,525** | **$ 566,140,525** |
| | | | | | |
| **Removed** | | | | | |
| No Eligibility Span | $ 1,718,987 | $ 1,718,987 | $ 1,718,987 | $ 1,718,987 | $ 1,718,987 |
| Dual | $ 193,397,135 | $ 193,397,135 | $ 193,397,135 | $ 193,397,135 | $ 193,397,135 |
| Commercial Insurance Coverage | $ 74,677,220 | $ 74,677,220 | $ 74,677,220 | $ 74,677,220 | $ 74,677,220 |
| No Fee Available | $ 5,634,956 | $ 5,634,956 | $ 5,634,956 | $ 5,634,956 | $ 5,634,956 |
| Zero Paid | $ - | $ - | $ - | $ - | $ - |
| Zero Repriced | $ 187 | $ 187 | $ 187 | $ 187 | $ 187 |
| **Total Removed** | **$ 275,428,486** | **$ 275,428,486** | **$ 275,428,486** | **$ 275,428,486** | **$ 275,428,486** |
| | | | | | |
| **Total Base Medicaid Data to Re-Price** | **$ 290,712,040** | **$ 290,712,040** | **$ 290,712,040** | **$ 290,712,040** | **$ 290,712,040** |
| **Total Base Medicaid Data Re-Priced to Jan 2015 Rates** | **$ 314,120,960** | **$ 314,120,960** | **$ 314,120,960** | **$ 314,120,960** | **$ 314,120,960** |
| **Total Medicaid Jan 2015 Rates where Comparable Rate Exists** | **$ 308,884,014** | **$ 313,318,025** | **$ 313,435,008** | **$ 308,826,438** | **$ 308,838,615** |
| **Total Comparable Rate** | **$ 276,452,594** | **$ 277,869,871** | **$ 253,734,692** | **$ 243,270,644** | **$ 172,253,481** |

***Note that due to the exclusions as well as removals and instances where a comparable rate does not exist, the estimated impact to Colorado of moving to a percentage of the Comparable Rate is distorted. In addition, dollars are estimated using FY2012-13 and FY2013-14 utilization, which will likely be lower than the current utilization.***

## Appendix II – Procedure Codes for Physician Administered Drugs

| J0120 | J0365 | J0637 | J0882 | J1322 | J1580 | J1826 | J2320 | J2675 | J2995 | J3396 | J7192 | J7508 | J7640 | J8562 | J9175 | J9293 | Q0180 | Q9960 | S0157 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| J0129 | J0380 | J0638 | J0885 | J1324 | J1590 | J1830 | J2323 | J2680 | J2997 | J3400 | J7193 | J7509 | J7641 | J8597 | J9178 | J9300 | Q0511 | Q9961 | S0164 |
| J0130 | J0390 | J0640 | J0886 | J1325 | J1595 | J1835 | J2323 | J2690 | J3000 | J3410 | J7194 | J7510 | J7642 | J8610 | J9179 | J9301 | Q0515 | Q9962 | S0166 |
| J0131 | J0395 | J0641 | J0887 | J1327 | J1599 | J1840 | J2325 | J2700 | J3010 | J3411 | J7195 | J7511 | J7643 | J8650 | J9181 | J9302 | Q2004 | Q9963 | S0169 |
| J0132 | J0400 | J0670 | J0888 | J1330 | J1600 | J1850 | J2353 | J2704 | J3030 | J3415 | J7196 | J7513 | J7644 | J8700 | J9185 | J9303 | Q2009 | Q9964 | S0171 |
| J0133 | J0401 | J0690 | J0894 | J1335 | J1602 | J1885 | J2354 | J2710 | J3060 | J3420 | J7197 | J7515 | J7645 | J8705 | J9190 | J9305 | Q2017 | Q9965 | S0174 |
| J0135 | J0456 | J0692 | J0895 | J1364 | J1610 | J1890 | J2355 | J2720 | J3070 | J3430 | J7198 | J7516 | J7647 | J8999 | J9200 | J9306 | Q2049 | Q9966 | S0176 |
| J0153 | J0461 | J0694 | J0897 | J1380 | J1620 | J1930 | J2357 | J2724 | J3095 | J3465 | J7199 | J7517 | J7648 | J9000 | J9201 | J9307 | Q2050 | Q9967 | S0179 |
| J0171 | J0470 | J0696 | J0945 | J1410 | J1626 | J1931 | J2358 | J2725 | J3101 | J3470 | J7200 | J7518 | J7649 | J9010 | J9202 | J9310 | Q4074 | S0014 | S0182 |
| J0178 | J0475 | J0697 | J1000 | J1430 | J1630 | J1940 | J2360 | J2730 | J3105 | J3473 | J7201 | J7520 | J7650 | J9015 | J9206 | J9315 | Q4081 | S0020 | S0183 |
| J0180 | J0476 | J0698 | J1020 | J1435 | J1631 | J1945 | J2370 | J2760 | J3110 | J3475 | J7300 | J7525 | J7657 | J9017 | J9207 | J9320 | Q4082 | S0021 | S0189 |
| J0190 | J0480 | J0702 | J1030 | J1436 | J1640 | J1950 | J2400 | J2765 | J3121 | J3480 | J7301 | J7599 | J7658 | J9020 | J9208 | J9328 | Q4100 | S0023 | S0195 |
| J0200 | J0490 | J0706 | J1040 | J1438 | J1642 | J1953 | J2405 | J2770 | J3145 | J3485 | J7302 | J7604 | J7659 | J9025 | J9209 | J9330 | Q4101 | S0028 | S4989 |
| J0205 | J0500 | J0710 | J1050 | J1439 | J1644 | J1955 | J2410 | J2778 | J3230 | J3486 | J7303 | J7605 | J7660 | J9027 | J9211 | J9340 | Q4102 | S0030 | S4993 |
| J0207 | J0515 | J0712 | J1071 | J1442 | J1645 | J1956 | J2425 | J2780 | J3240 | J3489 | J7304 | J7606 | J7665 | J9031 | J9212 | J9351 | Q4103 | S0032 | S5000 |
| J0210 | J0520 | J0713 | J1094 | J1446 | J1650 | J1960 | J2426 | J2783 | J3243 | J3490 | J7306 | J7607 | J7667 | J9033 | J9213 | J9354 | Q4104 | S0034 | S5010 |
| J0215 | J0558 | J0715 | J1100 | J1450 | J1652 | J1980 | J2430 | J2785 | J3246 | J3590 | J7307 | J7608 | J7668 | J9035 | J9214 | J9355 | Q4105 | S0039 | S5011 |
| J0220 | J0561 | J0716 | J1110 | J1451 | J1655 | J1990 | J2440 | J2788 | J3250 | J7030 | J7308 | J7609 | J7669 | J9040 | J9215 | J9357 | Q4106 | S0040 | S5012 |
| J0221 | J0571 | J0717 | J1120 | J1452 | J1670 | J2001 | J2460 | J2790 | J3260 | J7040 | J7309 | J7610 | J7670 | J9041 | J9216 | J9360 | Q4108 | S0073 | S5013 |
| J0256 | J0572 | J0720 | J1160 | J1453 | J1675 | J2010 | J2469 | J2791 | J3262 | J7042 | J7310 | J7611 | J7674 | J9042 | J9217 | J9370 | Q4110 | S0074 | S5014 |
| J0257 | J0573 | J0725 | J1162 | J1455 | J1700 | J2020 | J2501 | J2792 | J3265 | J7050 | J7311 | J7612 | J7676 | J9043 | J9218 | J9390 | Q4111 | S0077 | S5551 |
| J0270 | J0574 | J0735 | J1165 | J1457 | J1710 | J2060 | J2503 | J2793 | J3280 | J7060 | J7312 | J7613 | J7680 | J9045 | J9219 | J9395 | Q4112 | S0078 | |
| J0275 | J0575 | J0740 | J1170 | J1458 | J1720 | J2150 | J2504 | J2794 | J3285 | J7070 | J7315 | J7614 | J7681 | J9047 | J9225 | J9400 | Q4113 | S0080 | |
| J0278 | J0583 | J0743 | J1180 | J1459 | J1725 | J2170 | J2505 | J2795 | J3300 | J7100 | J7316 | J7615 | J7682 | J9050 | J9226 | J9600 | Q4114 | S0081 | |
| J0280 | J0585 | J0744 | J1190 | J1460 | J1730 | J2175 | J2507 | J2796 | J3301 | J7110 | J7321 | J7620 | J7683 | J9055 | J9228 | J9999 | Q4115 | S0088 | |
| J0282 | J0586 | J0745 | J1200 | J1556 | J1740 | J2180 | J2510 | J2800 | J3302 | J7120 | J7323 | J7626 | J7684 | J9060 | J9230 | Q0138 | Q4116 | S0090 | |
| J0285 | J0587 | J0760 | J1205 | J1557 | J1742 | J2185 | J2513 | J2805 | J3303 | J7131 | J7324 | J7627 | J7685 | J9065 | J9245 | Q0139 | Q4117 | S0091 | |
| J0287 | J0588 | J0770 | J1212 | J1559 | J1743 | J2210 | J2515 | J2810 | J3305 | J7178 | J7325 | J7628 | J7686 | J9070 | J9250 | Q0161 | Q4119 | S0092 | |
| J0288 | J0592 | J0775 | J1230 | J1560 | J1744 | J2248 | J2540 | J2820 | J3310 | J7180 | J7327 | J7629 | J7699 | J9098 | J9260 | Q0162 | Q4120 | S0093 | |
| J0289 | J0594 | J0780 | J1240 | J1561 | J1745 | J2250 | J2543 | J2850 | J3315 | J7181 | J7330 | J7631 | J7799 | J9100 | J9261 | Q0163 | Q4121 | S0119 | |
| J0290 | J0595 | J0795 | J1245 | J1562 | J1750 | J2260 | J2545 | J2910 | J3320 | J7182 | J7336 | J7632 | J8501 | J9120 | J9262 | Q0164 | Q9951 | S0136 | |
| J0295 | J0597 | J0800 | J1250 | J1566 | J1756 | J2265 | J2550 | J2916 | J3350 | J7183 | J7500 | J7633 | J8510 | J9130 | J9263 | Q0166 | Q9953 | S0137 | |
| J0300 | J0598 | J0833 | J1260 | J1568 | J1786 | J2270 | J2560 | J2920 | J3357 | J7185 | J7501 | J7634 | J8515 | J9150 | J9264 | Q0167 | Q9954 | S0140 | |
| J0330 | J0600 | J0834 | J1265 | J1569 | J1790 | J2274 | J2562 | J2930 | J3360 | J7186 | J7502 | J7635 | J8520 | J9151 | J9266 | Q0169 | Q9955 | S0142 | |
| J0348 | J0610 | J0840 | J1267 | J1570 | J1800 | J2278 | J2590 | J2940 | J3364 | J7187 | J7504 | J7636 | J8521 | J9155 | J9267 | Q0173 | Q9956 | S0145 | |
| J0350 | J0620 | J0850 | J1270 | J1571 | J1810 | J2300 | J2597 | J2941 | J3365 | J7189 | J7505 | J7637 | J8530 | J9160 | J9268 | Q0174 | Q9957 | S0148 | |
| J0360 | J0630 | J0878 | J1290 | J1572 | J1815 | J2310 | J2650 | J2950 | J3370 | J7190 | J7506 | J7638 | J8540 | J9165 | J9270 | Q0175 | Q9958 | S0155 | |
| J0364 | J0636 | J0881 | J1300 | J1573 | J1817 | J2315 | J2670 | J2993 | J3385 | J7191 | J7507 | J7639 | J8560 | J9171 | J9280 | Q0177 | Q9959 | S0156 | |

## Appendix III – Procedure and Revenue Codes with no Comparable Rate by Service

**Practitioner**

| Code | Medicaid Rate Range | Code | Medicaid Rate Range | Code | Medicaid Rate Range | Code | Medicaid Rate Range | Code | Medicaid Rate Range | Code | Medicaid Rate Range | Code | Medicaid Rate Range |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 15847 | $289.75 | 50323 | $1,588.54 | 78608 | $1,654.65 | 92352 | $10.09 | 99150 | $22.74 | A4262 | $0.25 | H2011 | $11.54 |
| 20930 | $113.13 | 50325 | $1,702.01 | 78815 | $1,409.56 | 92355 | $38.11 | 99172 | $14.82 | A4263 | $45.40 | H2036 | $156.31 |
| 20936 | $95.57 | 54440 | $101.31 | 78816 | $1,409.56 - $1,496.96 | 92370 | $13.62 | 99173 | $9.81 | A4264 | $1,630.87 | J0270 | $0.61 |
| 21743 | $878.36 | 58300 | $50.66 | 80050 | $44.27 | 92551 | $10.34 | 99174 | $16.49 | A4266 | $30.65 | J0715 | $8.91 |
| 27215 | $631.16 | 58578 | $480.88 | 80055 | $31.52 | 92605 | $148.51 | 99360 | $62.83 | A4267 | $0.28 | J0745 | $1.36 |
| 27216 | $349.18 | 58823 | $160.07 | 83891 | $5.13 | 92606 | $38.31 | 99363 | $129.19 | A4270 | $17.37 | J0833 | $66.88 |
| 27217 | $678.44 | 61542 | $1,823.58 | 83892 | $5.13 | 92630 | $49.54 | 99364 | $43.76 | A4300 | $8.21 | J0945 | $3.13 |
| 27218 | $936.78 | 61640 | $559.57 | 83900 | $45.76 | 92633 | $49.54 | 99381 | $112.17 | A4465 | $11.05 | J1094 | $0.25 |
| 33944 | $1,854.31 | 61641 | $201.94 | 83901 | $21.50 | 92700 | $25.13 | 99382 | $116.87 | A4550 | $54.71 | J1435 | $2.23 |
| 36000 | $22.29 | 61642 | $393.42 | 83912 | $5.42 | 92978 | $174.75 | 99383 | $121.93 | A4570 | $16.88 | J1700 | $2.98 |
| 36416 | $3.04 | 63043 | $341.41 | 86850 | $7.29 | 92992 | $1,005.83 | 99384 | $137.83 | A4648 | $139.03 | J1725 | $2.80 |
| 37195 | $217.14 | 63044 | $109.41 | 86870 | $19.89 | 93299 | $46.43 | 99385 | $133.83 | A5510 | $32.02 | J1810 | $9.89 |
| 37204 | $811.83 | 72291 | $1.85 | 86922 | $14.56 | 93571 | $183.67 | 99386 | $154.43 | A7003 | $2.02 | J2180 | $6.42 |
| 37205 | $367.76 | 73530 | $46.20 | 90281 | $15.33 | 93668 | $33.03 | 99387 | $167.80 | A7004 | $1.54 | J2590 | $1.04 |
| 37206 | $207.35 | 74190 | $47.05 | 90378 | $1,372.74 | 93770 | $6.81 | 99391 | $100.94 | A7006 | $4.85 | J2950 | $2.47 |
| 37207 | $395.78 | 74263 | $86.55 | 90384 | $118.00 | 94150 | $2.17 - $6.81 | 99392 | $107.81 | A9505 | $19.84 | J3030 | $87.88 |
| 37210 | $1,542.95 | 74300 | $38.50 | 90389 | $116.54 | 95130 | $13.62 | 99393 | $107.45 | E0100 | $18.28 | J3302 | $0.31 |
| 37216 | $751.72 | 74328 | $53.90 | 90636 | $108.23 | 95133 | $24.52 | 99394 | $117.57 | E0110 | $64.19 | J3490 | $0.55 |
| 41850 | $20.26 | 74360 | $21.48 | 90649 | $163.16 | 95134 | $27.24 | 99395 | $120.10 | E0114 | $37.31 | J7300 | $739.00 |
| 42508 | $439.01 | 74420 | $30.80 | 90650 | $163.16 | 95951 | $386.59 | 99396 | $128.05 | G0252 | $65.53 | J7302 | $888.55 |
| 42802 | $47.28 | 74425 | $30.80 - $53.90 | 90658 | $14.29 | 95965 | $497.93 | 99397 | $137.83 | G0260 | $68.07 | J7303 | $40.11 |
| 43256 | $174.93 | 74450 | $30.80 | 90707 | $54.49 | 96020 | $76.06 | 99401 | $36.92 | G0269 | $77.33 | J7304 | $18.91 |
| 43456 | $135.08 | 75894 | $154.00 | 90716 | $104.52 | 96040 | $27.11 | 99402 | $63.27 | G0398 | $110.67 | J7307 | $773.50 |
| 43458 | $130.35 | 75898 | $97.17 | 90718 | $29.40 | 96110 | $17.69 | 99403 | $88.18 | G0399 | $62.72 - $92.21 | J7636 | $3.54 |
| 43775 | $745.98 | 75945 | $156.00 | 90733 | $120.91 | 96376 | $30.25 | 99404 | $113.12 | G9006 | $11.55 | J7669 | $0.27 |
| 43881 | $1,171.82 | 76001 | $23.10 | 90734 | $112.11 | 96379 | $22.41 | 99408 | $35.77 | G9012 | $52.24 | L3201 | $50.87 |
| 44238 | $462.65 | 76140 | $21.56 | 90735 | $118.93 | 97010 | $4.48 | 99409 | $69.71 | H0001 | $99.66 | L3204 | $50.87 |
| 44393 | $304.94 | 76390 | $59.37 - $383.31 | 90863 | $32.25 | 97014 | $7.81 | 99411 | $16.68 | H0004 | $3.75 - $22.12 | L3260 | $153.22 |
| 44901 | $160.07 | 76496 | $32.65 - $81.54 | 90887 | $47.59 | 97602 | $31.75 | 99412 | $21.74 | H0005 | $29.30 | L3265 | $105.12 |
| 45339 | $165.14 | 76497 | $151.31 | 90989 | $486.50 | 99000 | $2.94 | 99420 | $10.48 | H0006 | $16.62 | L4210 | $22.78 |
| 45345 | $117.18 | 76498 | $15.79 - $79.00 | 90993 | $486.50 | 99001 | $2.85 | 0042T | $288.06 | H0020 | $14.40 | L7510 | $31.71 |
| 45383 | $282.65 | 76645 | $25.03 - $81.54 | 92015 | $9.54 | 99070 | $23.47 | 0075T | $717.61 | H0049 | $10.49 | L8680 | $277.92 |
| 47143 | $2,609.41 | 76940 | $127.13 | 92310 | $136.22 | 99143 | $50.12 | 0126T | $90.02 | H1000 | $103.53 | M0064 | $19.40 |
| 47145 | $2,439.54 | 76945 | $79.70 | 92314 | $89.91 | 99144 | $50.85 | 0159T | $82.24 | H1002 | $8.63 | Q0081 | $51.54 |
| 48551 | $2,042.41 | 76950 | $26.57 | 92340 | $16.35 | 99145 | $26.85 | 0191T | $1,231.54 | H1003 | $3.55 | Q3001 | $74.35 |
| 49659 | $611.91 | 76998 | $57.37 | 92341 | $10.09 | 99148 | $36.89 | A4212 | $3.42 | H1005 | $146.55 - $830.39 | Q3014 | $21.23 |
| 50021 | $160.07 | 78350 | $46.20 | 92342 | $22.91 | 99149 | $41.39 | A4220 | $66.45 | H1010 | $162.00 | Q9962 | $0.20 |

***Note that this list is simplified because the many modifier combinations associated with these procedure and revenue codes could not reasonably be included. In fact, some data with these codes was successfully re-priced and has been included in the analysis. Therefore, this list should be interpreted to mean that the given codes were at least in part unable to be re-priced at comparable rates.***

## Appendix III – Procedure and Revenue Codes with no Comparable Rate by Service (Continued)

**Practitioner (Continued)**

| Code | Medicaid Rate Range |
|---|---|
| S0020 | $10.33 |
| S0030 | $24.54 |
| S0077 | $15.97 |
| S0088 | $20.81 |
| S0164 | $34.18 |
| S0171 | $3.32 |
| S0390 | $52.01 |
| S0630 | $13.12 |
| S1015 | $17.89 |
| S2083 | $168.85 |
| S3005 | $22.57 |
| S3620 | $2.03 |
| S4981 | $50.66 |
| S4989 | $104.16 |
| S4993 | $35.00 |
| S5010 | $16.90 |
| S5011 | $16.76 |
| S5551 | $0.34 |
| S8100 | $32.97 |
| S8101 | $18.18 |
| S8450 | $13.90 |
| S8451 | $24.33 |
| S9445 | $12.52 |
| T1007 | $12.55 |
| T1017 | $11.59 |
| T1023 | $12.30 |
| T1026 | $284.41 |
| T2023 | $150.00 |
| V2610 | $18.25 |
| V2615 | $357.80 |
| V2781 | $59.09 |
| V2787 | $347.44 |
| V5010 | $52.50 |
| V5011 | $58.62 |
| V5014 | $206.28 |
| V5060 | $509.26 |
| V5090 | $154.70 |

| Code | Medicaid Rate Range |
|---|---|
| V5140 | $1,018.83 |
| V5246 | $1,021.38 |
| V5247 | $1,021.38 |
| V5253 | $1,021.38 |
| V5254 | $1,327.79 |
| V5255 | $1,327.79 |
| V5256 | $1,327.79 |
| V5257 | $1,327.79 |
| V5258 | $1,327.79 |
| V5259 | $1,327.79 |
| V5260 | $1,327.79 |
| V5261 | $1,327.79 |
| V5266 | $5.10 |
| V5275 | $39.08 |
| V5299 | $26.58 |

**HCBS Waiver**

| Code | Medicaid Rate Range |
|---|---|
| A0100 | $2.72 - $50.86 |
| A0120 | $8.30 |
| H0047 | $33.11 - $59.11 |
| H1010 | $1.00 |
| H2014 | $9.33 |
| H2018 | $80.37 |
| H2021 | $9.83 |
| S5161 | $1.00 |
| S5199 | $1.00 |
| T1999 | $1.00 |
| T2013 | $26.01 |
| T2024 | $1.04 |
| T2038 | $1.00 - $2,000.00 |
| T2043 | $34.70 |

**HH/PDN**

| Code | Medicaid Rate Range |
|---|---|
| 0583 | $10.43 - $55.21 |
| 0780 | $10.43 - $55.21 |
| 0911 | $390.77 |
| 0969 | $1.00 |
| 0999 | $1.00 |

**Dental**

| Code | Medicaid Rate Range |
|---|---|
| D0120 | $21.26 |
| D0140 | $31.86 |
| D0145 | $30.28 |
| D0150 | $36.65 |
| D0160 | $66.39 |
| D0210 | $54.17 |
| D0220 | $11.68 |
| D0230 | $11.68 |
| D0240 | $18.58 |
| D0250 | $26.55 |
| D0260 | $21.78 |
| D0270 | $12.21 |
| D0272 | $19.65 |
| D0274 | $27.61 |
| D0290 | $53.63 |
| D0310 | $132.23 |
| D0321 | $91.87 |
| D0322 | $209.78 |
| D0330 | $48.85 |
| D0340 | $55.23 |
| D0350 | $29.74 |
| D0365 | $164.14 |
| D0366 | $164.14 |
| D0367 | $164.14 |
| D0381 | $130.45 |
| D0382 | $130.45 |
| D0460 | $24.95 |
| D0470 | $45.15 |
| D1110 | $39.02 |
| D1120 | $29.20 |
| D1206 | $15.94 |
| D1208 | $10.84 |
| D1351 | $23.90 |
| D1510 | $137.55 |
| D1515 | $190.66 |
| D1520 | $170.48 |
| D1525 | $213.49 |

| Code | Medicaid Rate Range |
|---|---|
| D1550 | $34.53 |
| D1555 | $34.53 |
| D2140 | $57.35 |
| D2150 | $73.28 |
| D2160 | $86.57 |
| D2330 | $68.50 |
| D2331 | $84.98 |
| D2332 | $100.91 |
| D2335 | $126.39 |
| D2391 | $57.35 |
| D2392 | $73.28 |
| D2393 | $86.57 |
| D2394 | $103.04 |
| D2791 | $435.47 |
| D2910 | $46.20 |
| D2920 | $47.27 |
| D2930 | $118.95 |
| D2931 | $137.55 |
| D2932 | $148.72 |
| D2933 | $153.48 |
| D2934 | $163.04 |
| D2950 | $119.49 |
| D2951 | $29.20 |
| D2955 | $125.33 |
| D3110 | $35.06 |
| D3120 | $35.06 |
| D3220 | $82.32 |
| D3320 | $364.84 |
| D3333 | $122.15 |
| D3426 | $152.95 |
| D3430 | $116.82 |
| D3450 | $231.99 |
| D3910 | $88.68 |
| D3920 | $197.03 |
| D3950 | $107.28 |
| D4210 | $265.54 |
| D4245 | $366.98 |

| Code | Medicaid Rate Range |
|---|---|
| D4270 | $354.76 |
| D4274 | $294.75 |
| D4320 | $216.68 |
| D4341 | $107.81 |
| D4355 | $79.66 |
| D5422 | $39.29 |
| D5630 | $114.71 |
| D5760 | $200.22 |
| D5820 | $292.09 |
| D5821 | $292.09 |
| D5850 | $87.10 |
| D5932 | $1,132.80 |
| D5951 | $355.41 |
| D5952 | $386.49 |
| D5982 | $180.57 |
| D5986 | $84.44 |
| D5988 | $593.62 |
| D6060 | $543.82 |
| D6093 | $75.41 |
| D6211 | $425.91 |
| D7140 | $73.68 |
| D7210 | $119.49 |
| D7220 | $135.43 |
| D7230 | $173.13 |
| D7240 | $212.43 |
| D7241 | $252.27 |
| D7250 | $130.64 |
| D7260 | $335.11 |
| D7261 | $420.51 |
| D7270 | $232.61 |
| D7280 | $203.92 |
| D7283 | $228.89 |
| D7285 | $165.16 |
| D7290 | $204.47 |
| D7291 | $129.58 |
| D7340 | $421.67 |
| D7410 | $168.88 |

***Note that this list is simplified because the many modifier combinations associated with these procedure and revenue codes could not reasonably be included. In fact, some data with these codes was successfully re-priced and has been included in the analysis. Therefore, this list should be interpreted to mean that the given codes were at least in part unable to be re-priced at comparable rates.***

## Appendix III – Procedure and Revenue Codes with no Comparable Rate by Service (Continued)

**Dental (Continued)**

| Code | Medicaid Rate Range |
|---|---|
| D7411 | $250.14 |
| D7412 | $626.82 |
| D7441 | $451.25 |
| D7451 | $270.84 |
| D7460 | $215.10 |
| D7461 | $304.84 |
| D7465 | $163.58 |
| D7471 | $265.54 |
| D7472 | $313.85 |
| D7473 | $305.90 |
| D7490 | $3,558.21 |
| D7510 | $96.66 |
| D7511 | $279.84 |
| D7520 | $165.16 |
| D7521 | $234.22 |
| D7530 | $149.24 |
| D7540 | $308.00 |
| D7550 | $219.34 |
| D7560 | $481.15 |
| D7610 | $1,808.85 |
| D7620 | $1,431.78 |
| D7630 | $1,810.43 |
| D7640 | $1,397.79 |
| D7650 | $1,627.75 |
| D7670 | $573.03 |
| D7680 | $2,712.75 |
| D7720 | $1,409.49 |
| D7730 | $1,997.91 |
| D7740 | $1,505.06 |
| D7750 | $1,719.63 |
| D7770 | $1,123.75 |
| D7771 | $1,076.46 |
| D7780 | $3,360.12 |
| D7820 | $239.00 |
| D7830 | $318.11 |
| D7840 | $2,230.53 |
| D7850 | $3,472.42 |

| Code | Medicaid Rate Range |
|---|---|
| D7911 | $235.23 |
| D7912 | $377.20 |
| D7941 | $3,942.18 |
| D7945 | $4,595.87 |
| D7946 | $3,509.89 |
| D7947 | $3,652.73 |
| D7950 | $1,335.30 |
| D7955 | $2,260.59 |
| D7960 | $188.53 |
| D7963 | $212.43 |
| D7971 | $99.31 |
| D7972 | $309.09 |
| D7980 | $347.78 |
| D7983 | $518.87 |
| D7990 | $537.46 |
| D7997 | $120.56 |
| D8080 | $1,847.14 |
| D8090 | $3,163.48 |
| D8210 | $371.74 |
| D8220 | $424.86 |
| D8660 | $132.77 |
| D8691 | $163.40 |
| D8693 | $101.43 |
| D9110 | $50.45 |
| D9220 | $189.80 |
| D9221 | $82.20 |
| D9230 | $29.74 |
| D9241 | $189.80 |
| D9242 | $82.20 |
| D9248 | $132.77 |
| D9310 | $38.77 |
| D9420 | $106.22 |
| D9940 | $252.80 |
| D9951 | $73.84 |
| D9971 | $70.09 |

**EPSDT**

| Code | Medicaid Rate Range |
|---|---|
| 36416 | $3.04 |
| 58300 | $50.66 |
| 90708 | $29.19 |
| 90733 | $120.91 |
| 92341 | $10.09 |
| 92551 | $10.34 |
| 92630 | $49.54 |
| 92633 | $49.54 |
| 94150 | $6.81 |
| 94642 | $127.52 |
| 96110 | $17.34 |
| 97602 | $31.75 |
| 99000 | $2.94 |
| 99173 | $9.81 |
| 99174 | $16.49 |
| 99381 | $112.17 |
| 99382 | $116.87 |
| 99383 | $121.93 |
| 99384 | $137.83 |
| 99385 | $133.83 |
| 99391 | $100.94 |
| 99392 | $107.81 |
| 99393 | $107.45 |
| 99394 | $117.57 |
| 99395 | $120.10 |
| 99401 | $36.92 |
| 99402 | $63.27 |
| 99403 | $88.18 |
| 99408 | $35.77 |
| 99409 | $69.71 |
| 99420 | $10.48 |
| A4212 | $3.42 |
| A4262 | $0.25 |
| A7003 | $2.02 |
| D0145 | $30.28 |
| D0190 | $15.83 |
| D1206 | $15.94 |

| Code | Medicaid Rate Range |
|---|---|
| D1206 | $15.94 |
| H0049 | $10.49 |
| J2650 | $0.19 |
| S3620 | $2.03 |
| S8100 | $32.97 |
| S8450 | $13.90 |
| T1026 | |

**Independent Lab**

| Code | Medicaid Rate Range |
|---|---|
| 36416 | $3.04 |
| 76645 | $81.54 |
| 80050 | $44.27 |
| 80055 | $31.52 |
| 81220 | $1,542.95 |
| 81221 | $86.43 |
| 81228 | $659.62 |
| 81229 | $2,284.84 |
| 81401 | $194.33 |
| 81405 | $460.28 |
| 83890 | $5.13 |
| 83891 | $5.13 |
| 83892 | $5.13 |
| 83893 | $5.13 |
| 83894 | $5.13 |
| 83896 | $5.13 |
| 83897 | $5.13 |
| 83898 | $21.50 |
| 83900 | $45.76 |
| 83901 | $21.50 |
| 83902 | $18.21 |
| 83903 | $21.50 |
| 83904 | $21.50 |
| 83907 | $12.95 |
| 83908 | $16.25 |
| 83909 | $16.25 |
| 83912 | $5.42 |
| 83913 | $13.67 |
| 83914 | $16.25 |
| 86850 | $7.29 |
| 86870 | $19.89 |
| G0399 | $92.21 |
| P7001 | $16.28 |
| R0075 | $11.55 |
| S3854 | $2,793.66 |
| S8037 | $573.42 |

**Transportation**

| Code | Medicaid Rate Range |
|---|---|
| A0021 | $1.32 |
| A0080 | $0.38 |
| A0090 | $0.38 |
| A0100 | $48.86 |
| A0110 | $0.11 - $7,193.79 |
| A0120 | $15.62 |
| A0130 | $19.44 |
| A0140 | $90.75 - $1,490.32 |
| A0180 | $36.17 |
| A0190 | $15.92 |
| A0200 | $36.17 |
| A0210 | $15.92 |
| A0422 | $11.20 |
| A0999 | $3,470.37 - $8,540.50 |
| S0209 | $0.77 |
| T2003 | $1.69 |

**DME/Supplies**

| Code | Medicaid Rate Range |
|---|---|
| 92340 | $16.35 |
| 92341 | $10.09 |
| 92342 | $22.91 |
| A4206 | $0.16 |
| A4209 | $0.36 |
| A4211 | $9.70 |
| A4212 | $3.42 |
| A4213 | $1.85 |
| A4215 | $0.27 |
| A4218 | $0.24 |
| A4230 | $12.48 |
| A4231 | $7.58 |
| A4232 | $3.53 |
| A4245 | $0.04 |
| A4247 | $0.14 |
| A4250 | $0.51 |
| A4252 | $4.09 |
| A4266 | $30.65 |
| A4267 | $0.28 |
| A4305 | $6.69 |
| A4335 | $24.26 |
| A4465 | $11.05 |
| A4490 | $6.31 |
| A4495 | $8.26 |
| A4500 | $5.95 |
| A4510 | $13.49 |
| A4554 | $0.41 |
| A4570 | $16.88 |
| A4606 | $39.96 |
| A4627 | $34.73 |
| A4660 | $38.83 |
| A4663 | $20.36 |
| A4670 | $68.67 |
| A4772 | $0.71 |
| A4927 | $12.25 |
| A4930 | $1.26 |
| A5510 | $32.02 |

***Note that this list is simplified because the many modifier combinations associated with these procedure and revenue codes could not reasonably be included. In fact, some data with these codes was successfully re-priced and has been included in the analysis. Therefore, this list should be interpreted to mean that the given codes were at least in part unable to be re-priced at comparable rates.***

## Appendix III – Procedure and Revenue Codes with no Comparable Rate by Service (Continued)

**DME/Supplies (Continued)**

| Code | Medicaid Rate Range |
|---|---|
| A6198 | $32.11 |
| A6208 | $40.86 |
| A6213 | $13.39 |
| A6218 | $0.96 |
| A6221 | $8.49 |
| A6250 | $4.83 |
| A6260 | $9.79 |
| A6412 | $0.37 |
| A6530 | $17.61 |
| A6533 | $18.53 |
| A6534 | $43.96 |
| A6535 | $28.14 |
| A6536 | $25.11 |
| A6537 | $70.60 |
| A6538 | $80.11 |
| A6539 | $18.57 |
| A6540 | $57.89 |
| A6541 | $78.40 |
| A7011 | $11.65 |
| A7523 | $14.60 |
| A9281 | $18.01 |
| A9900 | $15.83 |
| B4034 | $4.85 |
| B4035 | $8.89 |
| B4036 | $6.31 |
| B4081 | $16.23 |
| B4082 | $12.60 |
| B4083 | $1.84 |
| B4102 | $0.66 |
| B4149 | $1.25 |
| B4150 | $0.57 |
| B4152 | $0.51 |
| B4153 | $1.65 |
| B4154 | $1.58 |
| B4155 | $2.82 |
| B4157 | $1.58 |
| B4158 | $1.18 |

| Code | Medicaid Rate Range |
|---|---|
| B4159 | $1.18 |
| B4160 | $1.65 |
| B4161 | $2.79 |
| B4220 | $5.91 |
| B4224 | $19.40 |
| B9000 | $71.35 - $1,124.07 |
| B9002 | $71.35 - $1,124.07 |
| B9004 | $233.16 |
| B9006 | $135.22 |
| E0190 | $255.56 |
| E0218 | $44.30 - $344.66 |
| E0241 | $19.73 |
| E0242 | $121.28 |
| E0243 | $32.61 |
| E0244 | $27.14 - $117.63 |
| E0245 | $48.52 - $164.64 |
| E0246 | $46.57 |
| E0247 | $91.63 - $171.51 |
| E0248 | $191.92 |
| E0273 | $97.04 |
| E0274 | $101.20 |
| E0315 | $97.04 |
| E0425 | $38.35 |
| E0430 | $27.35 |
| E0435 | $78.59 |
| E0440 | $43.13 |
| E0445 | $356.72 - $732.93 |
| E0555 | $27.50 - $50.24 |
| E0603 | $2.20 |
| E0625 | $776.24 |
| E0700 | $76.64 |
| E0710 | $112.44 |
| E0936 | $49.70 |
| E0970 | $32.40 |
| E1130 | $291.10 |
| E1229 | $50.06 |
| E1250 | $43.36 |

| Code | Medicaid Rate Range |
|---|---|
| E1290 | $1,437.28 |
| E1354 | $23.51 |
| E1356 | $500.91 |
| E1358 | $608.25 |
| E2291 | $460.02 |
| E2292 | $460.02 |
| K0462 | $142.69 |
| K0739 | $25.82 - $158.66 |
| K0740 | $153.20 |
| K0884 | $9,200.44 |
| L3201 | $50.87 |
| L3202 | $43.40 |
| L3203 | $30.45 |
| L3204 | $50.87 |
| L3206 | $120.22 |
| L3207 | $114.91 |
| L3212 | $69.54 |
| L3215 | $114.91 |
| L3216 | $114.91 |
| L3217 | $120.22 |
| L3219 | $92.52 |
| L3221 | $96.79 |
| L3222 | $138.21 |
| L3230 | $239.41 |
| L3250 | $368.39 |
| L3252 | $242.58 |
| L3257 | $107.28 |
| L3260 | $153.22 |
| L3265 | $105.12 |
| L3320 | $61.22 |
| L3485 | $24.81 |
| L4205 | $18.90 |
| L4210 | $22.78 |
| L7260 | $1,490.11 |
| L7510 | $31.71 |
| L7520 | $15.62 |
| L8010 | $51.62 |

| Code | Medicaid Rate Range |
|---|---|
| S1040 | $2,522.36 |
| S8120 | $0.07 |
| S8121 | $0.77 |
| S8186 | $3.70 |
| S8422 | $84.74 |
| S8423 | $114.71 |
| S8424 | $41.96 |
| S8425 | $141.03 |
| S8427 | $121.61 |
| S8428 | $30.58 |
| S8450 | $13.90 |
| S8451 | $24.33 |
| S8452 | $25.71 |
| S8490 | $20.43 |
| S8999 | $107.93 |
| T4521 | $0.64 |
| T4522 | $0.74 |
| T4523 | $0.88 |
| T4524 | $0.90 |
| T4525 | $0.64 |
| T4526 | $0.83 |
| T4527 | $1.01 |
| T4528 | $1.00 |
| T4529 | $0.45 |
| T4530 | $0.45 |
| T4531 | $0.62 |
| T4532 | $0.62 |
| T4533 | $0.57 |
| T4534 | $1.01 |
| T4535 | $0.43 |
| T4543 | $1.43 |
| V2781 | $59.09 |

***Note that this list is simplified because the many modifier combinations associated with these procedure and revenue codes could not reasonably be included. In fact, some data with these codes was successfully re-priced and has been included in the analysis. Therefore, this list should be interpreted to mean that the given codes were at least in part unable to be re-priced at comparable rates.***

## Appendix IV – Programs Description

The following is a brief description of the services included in this report:

| Service Name | Service Description |
|---|---|
| Practitioner | Services provided by a medical doctor who attests as having a primary specialty designation of family medicine, general internal medicine, or pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties, the American Board of Physician Specialties, or the American Osteopathic Association. Payment is made based on the fee-schedule with some selected services eligible for increased payment. |
| HCBS Waiver | Waiver programs provide additional Medicaid benefits to specific populations who meet special eligibility criteria. In Colorado, Home and Community Based Services are offered to adults and children. Medicaid HCBS uses four payment methodologies: 1. Bundled Payments, 2. Fee-for-Service, 3. Negotiated Market Price and, 4. Tiered Rates. Each waiver has an enrollment limit. |
| HH/PDN | Home health includes services provided by a licensed and certified home health agency for clients who need intermittent skilled services at home. Home health services consist of skilled nursing (provided by a Registered Nurse or Licensed Practical Nurse), Certified Nurse Aide (CNA) services, physical therapy (PT), occupational therapy (OT), and speech/language pathology (SLP) services. Home health services are a state plan benefit for Colorado Medicaid clients, including children and adults. The services are billed fee for service using revenue codes. |
| Dental | Comprehensive dental services are a Colorado Medical Assistance program benefit for Medicaid clients ages 20 and under who are enrolled in state Medicaid services. Enrolled children are entitled to preventive dental services including exams, cleanings, x-rays, sealants, space maintainers and fluoride treatments. Restorative procedures such as amalgam and tooth colored fillings, crowns, root canals, gum and oral surgery procedures are also available. Orthodontic benefits (braces) may be available in the case of a child with a severe handicapping malocclusion (i.e., bite) problem. Dental services for children are billed fee for service using ADA CDT codes. |
| EPSDT | Physician services for routine medical care including services provided in the office, at a facility, or in the home. Providers include physicians, mid-level practitioners, optometrists, podiatrists, and nurses. The services are a state plan benefit for all enrolled Colorado Medicaid clients, however, specific procedure codes are age limited. |
| Independent Laboratory | An independent laboratory is a certified laboratory that performs diagnostic tests and is independent both of the attending or consulting physician's office and of a hospital. Payment to independent laboratory services are based on procedure codes and it is calculated by Colorado Medicaid at the lower of submitted charges or the laboratory fee schedule determined by the Department. |
| Transportation | Emergent (EMT) and Non-Emergent (NEMT) Transportation services provide clients access to medical appointments and hospitals when medically necessary. Transportation services are provided by approved Public Utilities Commission (PUC) contract carriers and are administered by a brokerage in the Denver Metro area and by counties outside of the Denver Metro area. Transportation services are a state plan benefit for Colorado Medicaid clients, including children and adults. The services are billed fee for service using HCPCS codes. |
| DME/Supplies | The Department pays for Supplies and DME by using the fee-schedule, the Manufacturer's Suggested Retail Price (MSRP) or, by invoice. Codes reimbursed according to the fee-schedule are subject to the lower of payment up to the maximum allowable rate. If the code doesn't have a maximum allowable rate, a reduced percentage of the MSRP is paid. Lastly, if the code doesn't have a maximum allowable rate or MSRP, the Department pays at a percentage over the actual acquisition invoice amount. |